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ABSTRACT

The instructor-free, empirically-based training package is designed to teach personnel at all levels to develop and implement individual program plans for severely handicapped, developmentally disabled persons in their own agencies. The package consists of a six-chapter trainee workbook (individual program planning and the interdisciplinary team, goals, objectives, strategies, evaluation, and application) which presents information as well as directions for proceeding through the exercises and provides the trainee with a permanent record of the training experiences and a reference source. An appendix provides references for further information, data on standards, background reports on a practice client, and suggested forms. (BD)

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WORKBOOK

INDIVIDUAL PROGRAM PLANNING WITH DEVELOPMENTALLY DISABLED PERSONS

Revised Edition

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Jerry Parham

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Texas Tech University
Lubbock, Texas 79409

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IPP

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Originally published in 1976 as "Individual Program Planning with the Developmentally Disabled." Revised Edition 1977

This workbook for trainees is part of a training package, *Individual Program Planning with Developmentally Disabled Persons,* which also includes two videotapes and a manual for administrators, "How to Implement and Maintain an Individual Program Planning System."

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The content and methods of training were refined at live presentations of the material. Dr. Andrew Martin, Research and Training Center in Mental Retardation, helped integrate the concept of strategies into the model of individual program plans and presented his concept at several of the live training sessions. Dr. Max Joiner, of Auburn University, Dr. Louis Brown, of the University of Wisconsin, Dr. Robert Flexer, of the Research and Training Center, Mr. Dan Danos, of the Louisiana Department of Vocational Rehabilitation, and Dr. Kenneth Crosby, of the Joint Commission on Accreditation of Hospitals, also assisted at live presentations of the training.

The model of the individual program plan, consisting of goals, objectives, strategies, and evaluation, is based on the model presented by Drs. James Gallagher and Richard Surles, of the Frank Porter Graham Child Development Center, in *Program Planning and Evaluation*. We have borrowed heavily and often directly from "Goal Planning with Developmentally Disabled Persons," by Drs. Peter Houts and Robert Scott of the Milton S. Hersey Medical Center in Pennsylvania. The publication, "How to do MORE," produced under the direction of Dr. James Lent at the George Peabody College for Teachers, Nashville, Tennessee, was particularly helpful as we prepared materials on treatment strategies and evaluation. Robert F. Mager's *Preparing Instructional Objectives* was useful in developing Session 3. Drs. Kenneth Crosby, Marc Gold, and James Kopp contributed not only their lectures on videotape, but also ideas that we used in the written part of the package. Marc Gold's research on strategy development shaped our own concepts significantly.

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The trainees who participated in the live presentation of the training and those who served as subjects in testing the instructor-free package provided critical data and valuable suggestions about the program. Special recognition is due Dr. Jean Cooper, Director of Staff Development at Fort Worth State School, and the employees of the school for their cooperation in our testing of the instructor-free package.

IPP

A NOTE TO GROUP MEMBERS

HOW TO MAKE INSTRUCTOR-FREE TRAINING WORK FOR YOU

Please read this section before Session 1.

You are about to begin a kind of training that may be a new experience for you—group self-instruction. Over the next few weeks, you will meet six times for approximately 2 hours with the other members of your group to work through the sessions of this training in individual program planning with developmentally disabled persons. There will be no instructor, so as a group, you will take an active role in teaching yourselves. The information which follows will tell you what to expect from the training and what is expected from you.

THE TRAINING MATERIALS

Workbooks

You will be using the workbook you are holding now for each of the six sessions. This workbook contains the basic content of the training as well as careful directions telling you what to do when and approximately how long to spend at each task. There is space provided in the workbook for taking notes and completing exercises. Note paper is also provided at the back of the workbook for you to use when you need more space to write (during group discussions, exercises, and videotape presentations, for example). You can remove these notes and insert them in the appropriate place in your notebook.

Videotapes

In Sessions 1, 2, 3 and possibly 6, you will watch some videotaped lectures and clients. There are two tapes in the training package. Use Tape 1 for Session 1. Use Tape 2 for the remaining sessions. It is important that you view the videotapes in sequence and at the appropriate time. The workbook indicates which tapes to watch and when.

Blackboard or easel and pad

The room where you meet should have a blackboard and chalk, or easel with a large writing pad and magic marker, so that you can make notes for all to see as you discuss possible responses to exercises. When the group reaches a consensus (that is, when all of you agree upon an answer or response), you may record this consensus in your workbooks for future reference.

GROUP SELF-INSTRUCTION: HOW IT WORKS

Interaction

In this kind of training, group members are equals, and each participates actively in trying to understand the material and helping others in the group understand it. Except for the individual practice assignments between sessions, you will all work together throughout the training, reading the workbook, watching the videotapes, and completing the exercises.

Participation

To help group members stay together as they go through the material in the workbook, and to encourage every person to participate during each session, we have suggested that you take turns reading paragraphs aloud. However, some people may feel more comfortable doing this than others. If this is the case in your group, those who do not like to read may wish to take a more active role in the other activities such as group discussions. There are many ways to contribute to the group, so it is not necessary for everyone to participate to the same degree in every area. The most important thing is that the group members work together and that each person be given the chance to participate in the way that suits him or her best.

Sometimes the information presented may seem confusing to all of you. In such cases group discussion may help. When you can't resolve your confusion quickly, continue reading in the workbook and chances are your questions will be answered shortly.

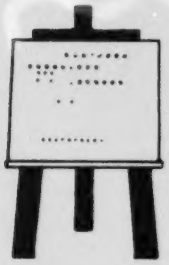
Self-critiques

The group will work together on all of the exercises. Since there is no instructor to tell you whether what you are doing is "right" or "wrong," you will have to depend on yourselves for feedback. Every exercise that you are asked to do is followed by directions for self-critique. This means that as a group you should go over your answers according to the guidelines that are given to you in the workbook. Since there are several people in a group all checking for possible alternative responses, the chances are very good that your answers, after critiquing, will be correct. If you still feel a need for outside reassurance, however, the person in your agency who is in charge of the IPP system (probably the person who gave you this book) will be available to answer your questions.

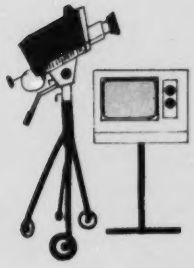
VISUAL CUES

In addition to written instructions telling your group how to proceed through each part of the training, three visual cues are repeated throughout the workbook to indicate group activities.

When you see these faces, group discussion will be helpful. Sometimes you will debate the best responses to an exercise. At other times you are asked to set your workbooks aside and share experiences and ideas on a specified topic.



This picture of an easel and pad indicates that making notes of discussions for everyone to see will help the group clarify its thinking and reach a consensus.



"Effective Communication"

Miss Interpretation

Approximate counter numbers 036-112
*Presentation ended at counter number*_____

The camera and monitor indicate that it is time to watch a videotape. This example tells you to turn on the videotape equipment to view the audiovisual presentation on "Effective Communication" by Miss Interpretation. The counter numbers tell where the presentation begins (036) and where it ends (112). Video playback machines vary, so these numbers are only approximate. If you start your tape at 000, your numbers will correspond roughly to those given in the workbook. But as you finish each tape, record in your workbook the counter numbers that appear on your machine. Then you will know exactly where to begin the next segment of tape.

RESPONSIBILITIES OF GROUP MEMBERS

1. As part of a group engaged in self-instruction, your primary responsibility is to participate actively in all phases of the training. This means that you should share your ideas in group discussions, contribute as the group works on exercises, and take your turn reading aloud. Each group member's ideas are valuable to the group as a whole!

   Your responsibility to participate also means that you must ask questions as you have them. Chances are that if you have a question, someone else in the group is wondering about the same thing. Do yourself, and the group, a favor by asking about it. If you don't, you risk getting even more confused as the training proceeds.

   Your input affects the entire group. Be open, honest, and sharing.

2. Try to be positive as well. When you are constructive in your comments, others will feel freer to share ideas. And concentrating your comments on the material in the training package—rather than complaining about your agency, job, or personalities—is the most productive use of group time. Being constructive also encourages others to be positive toward you. They will want to hear what you have to say and seek out your opinions.

3. Be sensitive to the other people in your group. While not all group members have the same background, training, and experience, you will facilitate good group relationships if you approach the training from the point of view that each person's opinions are to be valued equally. Thus, if you sense that the group is proceeding at a pace that is too rapid for some members, suggest that the group take more time. If some group members are more hesitant than others about participating, try to think of ways to involve them comfortably. You set precedents in this training for the way in which your team will work when the training is completed.

4. Attend each of the six sessions, be on time for the meetings, and don't permit interruptions.

5. Complete the individual practice assignments that are scheduled between training sessions. These assignments give you a chance to work on the various parts of an IPP at your own pace. During the session following an assignment, the group will review the individual work.

RESPONSIBILITIES OF THE GROUP AS A WHOLE

1. Set group policies regarding absenteeism, late arrivals, failure to do individual practice assignments, and make-up sessions. Try to prevent problems, and handle them positively rather than punitively when they arise. For example, if someone must miss a scheduled session and notifies you ahead of time, try to reschedule the meeting. It is preferable that the group handle its own questions or problems when possible, but if you must consult the person in charge of the IPP system, feel free to do so.

2. Appoint a coordinator for each of the six sessions. The coordinator will have the following responsibilities:

   (a) Schedule the meeting room.

   (b) Make sure the group knows the time and place of the next session.

   (c) Reserve the necessary equipment.

   (d) Do any writing at the blackboard or easel that is necessary as the group works together on exercises.

   (More complete directions for appointing the coordinator appear in Session 1.)

3. Appoint someone to operate the audiovisual equipment. Each group member, however, should become familiar with the videotape player so that he or she will be able to start, stop, and rewind the tape when necessary.

4. Follow the training in the sequence in which it is presented and do all of the assignments. The workbook tells how long you should expect to spend at a task. These time limits, however, are only guidelines to help you keep the training proceeding at a reasonable pace. Do not feel compelled to stick to them rigidly, but don't let things bog down either.

5. Enjoy your training! While the nature of the training requires that you approach it seriously, learning ought to be fun. So relax and come to the training in good spirits. Frequently, important points can be remembered better when made with some humor.

BEFORE SESSION 1—A BRIEF CHECKLIST:

1. Make sure you know where and when to meet.
2. Take this workbook with you to the meeting.
3. Be prepared to be positive and relaxed—and to enjoy yourself!

IPP

SESSION 1: INDIVIDUAL PROGRAM PLANNING AND THE INTERDISCIPLINARY TEAM

Here is what you will do:

Introduce yourselves.

Watch a videotape defining and presenting the reasons for the individual program plan.

Discuss with other group members how IPPs relate to your own situation as rehabilitation workers.

Watch a second videotape distinguishing between unidisciplinary, multidisciplinary and interdisciplinary teams.

As a group, organize yourselves into an interdisciplinary team.

Formulate team objectives.

Watch a third videotape on what "making it" in society means for you and your clients.

At the end of this session you will know how to:

Organize into an interdisciplinary team.

Note: Before beginning Session 1, read "A Note to Group Members" on page 1. You will also need to set up the video equipment.

SESSION 1

Choose one person to read these three paragraphs aloud.

Throughout these training sessions on individual program planning with developmentally disabled persons, you will be watching videotapes, reading printed information in your workbooks, and applying what you've learned in written exercises.

Because individual program planning requires a **team** approach, this package is designed to encourage group interaction. Take turns **reading the printed information aloud**, and complete the exercises by **coming to a group consensus** (agreement) after sharing individual opinions. Learning to act as a team is the first step toward effective planning with clients.

INTRODUCTIONS

You will work together better as a team if you know and respect one another. So take a few minutes now to introduce yourselves, giving your names and a brief description of your backgrounds.

NOTES _____

INDIVIDUAL PROGRAM PLANNING

Let a second person read these paragraphs.

Session 1 begins with an introduction on videotape to individual program planning. Dr. Jerry Parham, of the Texas Tech University Research and Training Center in Mental Retardation, will explain the what and why of individual program plans (IPPs). You may take notes in the space below.

Set your video playback machine at counter number 000 and turn on Tape 1. Watch the tape until Dr. Parham finishes speaking and you see STOP *on the screen.*

When the lecture is over, stop the tape. Record in the space below the counter number on your machine. Then continue as directed in your workbook.

"Individual Program Plans:

What and Why"

Dr. Jerry Parham

Approximate counter numbers 000-350
Presentation ended at counter number _____

NOTES _____

REVIEW: INDIVIDUAL PROGRAM PLANS

The outline below summarizes the main points of Dr. Parham's talk,"IPPs: What and Why." Proceeding clockwise from the last reader, continue to take turns reading aloud the numbered parts of this review. Feel free to pause during the reading to discuss any questions you may have or to clarify any confusing points. Keep in mind, though, that much of this material will become clearer to you as you work through this training. Try to limit the review to 5 minutes.

1. **Individual program plans (IPPs) are written plans of education and training.**

   They are written for each person accepted for services.

   They are written by a team.

   They are written with the maximum involvement of the client, or with the client's parent or advocate.

   They are written and revised continuously, as long as the client is being served.

2. **IPPs have four basic parts.**

   Goals state the direction of the program in a general and subjective way. A good way to decide what goals to work for is to think of a client's strengths and needs.

   Objectives define the behavior you want the client to display when the training is completed. Objectives are more specific than goals.

   Strategies are the procedures you intend to use in helping the client learn the desirable behavior.

   Evaluation means gathering data each time you work with a client so you will know whether the training is succeeding.

3. **IPPs reflect a new and positive focus in dealing with developmentally disabled persons.**

   They emphasize the positive aspects of client behavior rather than the problems.

   They stress what clients can do for themselves.

   They guard against giving clients labels—and therefore limits.

4. **IPPs are required.**

They are required for **accreditation** by organizations such as JCAH, CARF and ICF-MR.*

They are required by **legislation** that is linked to various funding sources.

They are required by **litigation**. A majority of recent court decisions have supported the client's right to specific services in the least restrictive environment.

5. **Even more important, IPPs are helpful to the client.**

They tell the client exactly what is expected of him or her.

They motivate by letting the client participate in planning his or her own program.

They aid the client in gaining skills and independence.

6. **IPPs also help you.**

They outline the purpose and direction of treatment.

They state your intentions specifically.

They state who is responsible for what and when.

They aid in developing programs for even the most difficult clients.

They provide a record of your achievements.

Continue taking turns reading the following paragraphs.

Perhaps you thought of some possible objections to individual program planning as you listened to the videotape and then reviewed the information. Let's consider some of the questions that might have come to mind.

Won't writing IPPs be time-consuming and create more paperwork?

Individual program plans are designed to take the place of—not duplicate—much of the paperwork you're now required to do. And, because they provide a framework for organizing client background, program goals and progress, they may even save you some time. Like any new format, IPPs take some getting used to. But as you become familiar with the steps involved, each IPP will be easier and faster than the one before.

*JCAH—Joint Commission on Accreditation of Hospitals
CARF—Commission on Accreditation of Rehabilitation Facilities
ICF-MR—Intermediate Care Services in Facilities for the Mentally Retarded
Refer to Appendix A for more detailed information concerning legislation, litigation and accreditation as they apply to individual program planning.

Realistically, how much can our clients achieve? Isn't there a danger of expecting too much of them or holding out false hope?

In general, people will do as much—or as little—as we expect of them. Developmentally disabled people are no exception. When our expectations for them are low, they are likely to achieve little. But if the task is something clients want to learn and the proper teaching strategies are employed, you'd be surprised what they can achieve.

But don't our clients need us to do things for them? Can they really handle increased responsibility and independence?

One of the best things you can do for clients is to teach them the skills needed to accomplish tasks without assistance. Your jobs will not end as your clients become more independent; they will only change. Rather than tending solely to the day-to-day needs such as feeding and toileting, you will be challenged to help clients develop self-help skills, social skills, and marketable job skills.

How can we develop individual program plans for every client when we're already understaffed?

Any new system takes time to implement, so begin with one or two clients at a time. Because your aim is to build client skills, you will find that less and less time is spent in "taking care of" those clients in the long run. As they become more independent you will have more time to devote to setting goals for them and developing individual program plans for other clients.

DISCUSSION: HOW CAN IPPs HELP?

As you work as a group throughout this training, you will probably develop relationships that will allow you to participate comfortably in group discussions. However, it's common to feel somewhat uncomfortable in the beginning, especially if the members of the group don't know one another very well.

And remember, once the group discussion gets started, it should take a positive direction in order for everyone to benefit. It's okay to disagree with other group members, but do it constructively—not as a personal put-down.

Take about 10 minutes to discuss how IPPs could help you and your clients. Think of your own experiences in your agency. For example, how will it help you to have the exact training procedures written down?

THE INTERDISCIPLINARY TEAM

Continue to take turns reading.

IPPs are written by a team of persons with different backgrounds and different strengths. Although each team member may have special interests in one particular aspect of the client, all members of the team are interested in the client's total development and are free to express views about any program area.

This is called an **interdisciplinary team**. You, too, will be part of an interdisciplinary team, both in this training and on your job.

Dr. Kenneth Crosby, of JCAH, will explain the interdisciplinary team concept. You will find the information helpful in defining your role as a team member. You may take notes on this page. Listen especially for Dr. Crosby's definition of unidisciplinary team, multidisciplinary team, and interdisciplinary team.

Now turn on the TV monitor at the counter number where you stopped the first video presentation. Watch until Dr. Crosby finishes talking and you see STOP *on the screen. Record the counter number where you stop in the space below.*

"The Interdisciplinary Team"

Dr. Kenneth Crosby

Approximate counter numbers 357-620
Presentation ended at counter number _____

NOTES _____

REVIEW: THE INTERDISCIPLINARY TEAM

Take turns reading aloud this review of the interdisciplinary team concept. Interrupt your reading, if necessary, for questions and discussion.

1. The unidisciplinary team.

"Unidisciplinary" means one discipline, or one profession.

The unidisciplinary team concerns itself with only one aspect of a client's needs, such as medical needs, educational needs, or social needs.

There is no client representation on the unidisciplinary team.

2. The multidisciplinary team.

"Multidisciplinary" means several disciplines or professions.

A person on a multidisciplinary team can contribute to the client's program only in his or her special area.

Team members each write separate plans for a client.

The client is seldom represented on a multidisciplinary team.

3. The interdisciplinary team.

"Interdisciplinary" means that persons of various backgrounds interact, or work together.

No matter what their professional backgrounds, team members are encouraged to express their opinions on any aspect of a client's strengths and needs. For example, a speech therapist is free to offer suggestions about improving a client's physical fitness.

Direct care staff members are an essential part of the interdisciplinary team.

The members of an interdisciplinary team together write one overall program for a client. Each separate part of the plan—that is, the part dealing with the client's socialization, education, or medical problems—is integrated into the total plan.

Team members then implement programs for which they are assigned responsibility by the team.

QUESTIONS AND DISCUSSION: THE INTERDISCIPLINARY TEAM

Read aloud the following questions and responses. If group members have further questions about the interdisciplinary team, discuss those questions as a group and rely on your own experience, judgment, and common sense to determine the answers to the questions.

Who decides what people will be on an interdisciplinary team?

The team membership is determined by the needs of the individual being served. A core team, which consists of all those who have direct and regular contact with the client, must have access to specialists if they are needed by a particular client.

Sometimes you have to develop a team for a new client on the basis of the "best guess." That is, until you have a chance to work with the client, you form a team of people who will probably be the ones having direct contact with him or her. The team will change as the client's needs change.

Can a psychologist or a physician be overruled by a team?

Everything done with, for, or to a client must be agreed on by the team. You can't have professional people going off in separate directions. Team oversight of the client's program prevents this fragmentation. So if a physician's proposal for drug therapy conflicts with the client's overall program, the team can veto the drug therapy.

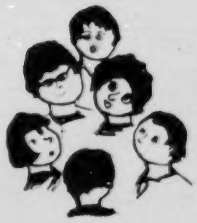
What if we can't afford to have a psychologist and physician on every team?

These professional people don't need to be on every team! Interdisciplinary team activities are carried out by the people who have direct contact with a client. If a doctor or psychologist sees a client only once a year, that professional does not need to be a part of the core team.

Won't being an active member of an interdisciplinary team place unreasonable demands on a direct care person's time?

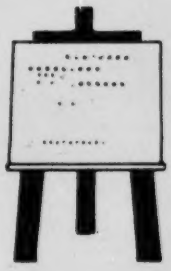
The rewards of helping to design a client's program and then working to reach the goals you have helped establish will make up for the time you spend in a team meeting or working on a program plan. And since you will know the reason for everything you do with a client, you will be able to use your time more purposefully and efficiently.

EXERCISE: TEAM ORGANIZATION



Throughout this training you will act as a core interdisciplinary team. Using the information from the videotape and workbook, consider the membership and organization of your team. You will have the opportunity to reorganize your team, if necessary, after you meet your practice client, but the team you organize now will remain essentially intact through Session 6.

Take a few minutes now to organize yourselves into a **core interdisciplinary team**. *You will find writing on the blackboard or an easel, where everyone can see, makes it easier for the whole group to participate. After you decide as a group on your organization, record it on the following page for future reference.*



If your group is already a core interdisciplinary team, that is, if you work together with clients in your agency, read the directions at point **A** *below. If you have not worked together as a team prior to this training, read the directions at point* **B** *below.*

A. If you are presently an interdisciplinary team, *record your names and areas of responsibility on the Team Organization Form on the next page.*

B. If you are not an intact team, *form a team by adopting roles. These roles should reflect your own backgrounds and competencies as closely as possible; however, some modification may be necessary to insure that your team consists primarily or entirely of direct care staff, that is, people who have direct and regular contact with clients. Record your names on the next page and decide, as a group, what role each person should assume.*

TEAM ORGANIZATION FORM

Name of Team Member	Area of Responsibility

CRITIQUE

Now consider your team organization in light of the following questions.

Does your team consist of direct care staff?

Are there any professionals (psychologists, physicians, etc.) who might better serve as consultants rather than as members of the core team?

Is the function of each team member, as well as his or her job title, clear? For example, you may have listed a "developmental specialist" on the team, but does everyone know what a developmental specialist will contribute to a client's program?

Is your team well balanced? That is, are various areas of education and training neither over- nor under-represented?

Take about 5 minutes to consider these questions and make any necessary revisions on your Team Organization Form.

The second part of this Team Organization Exercise is to appoint team coordinators for each of the six training sessions.

On an interdisciplinary team, the person who has the greatest contact with the client is the team coordinator.* This person assumes responsibility for the client, coordinates the program plan, and encourages the client's participation. For the purpose of this training, however, each team member should have a chance to act as coordinator. You will need a coordinator (or coordinators) for each of the six sessions. The coordinator will have the following responsibilities:

1. Schedule the meeting room.
2. Make sure the group knows the time and place of the next session.
3. Reserve the necessary equipment.
4. Do any writing at the blackboard or easel that is necessary as the group works together on exercises.

Choose the coordinator now and record the appropriate session number to the left of each team member's name on the Team Organization Form on the preceding page. Be sure to appoint a coordinator for the remainder of Session 1.

* The 1975 Amendments to the Developmental Disabilities Services and Facilities Construction Act (Public Law 94-103)—as well as JCAH and CARF—specify that each client's interdisciplinary team should have a "facilitator" or "program coordinator."

Continue taking turns reading.

You have just completed your first exercise—organizing into an interdisciplinary team. Did you have difficulty reaching a group consensus? Were there questions you were not able to resolve?

Since this training is designed to be instructor-free, you as a group must make decisions whenever possible on your own. However, if there are times that the group is not able to resolve an issue, you should act just as an interdisciplinary team would act—that is, call in a consultant you feel is qualified to help. The person in charge of the IPP system in your agency will be familiar with this training and be able to provide any additional information you need about the package itself.

EXERCISE: TEAM TRAINING OBJECTIVES

As an interdisciplinary team, decide what you would like to achieve in this training. One way for you to set training objectives is to determine your team's strengths and needs. Let the coordinator return to the blackboard or easel now and record your suggestions as you work together on a team strengths/needs list. You can learn about the team by learning about individual members, but focus on the strengths and needs you have as a group rather than as individuals.

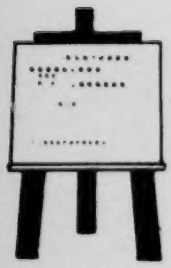
Under **strengths**, list:

sources of support for the interdisciplinary team, such as parents or other relatives of clients, and your agency's administrators and staff

experience working together as a team

experiences of team members working with interdisciplinary teams and/or individual program plans

skills, interests, and attitudes that will help you respond positively to client-centered training



Under **needs**, list:

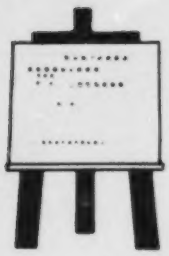
what you would like to accomplish in order to improve your ability to write IPPs. State your needs positively and specifically. Think about group relationships as well as about your specific program planning skills.

When you have reached a group consensus on strengths/needs, record the consensus here in the workbook for future reference. Finish your list in 10 minutes.

TEAM STRENGTHS/NEEDS LIST

Strengths	Needs

IPP



Your team objectives should reflect the group's current strengths and needs. The coordinator can continue to work at the blackboard or easel as you discuss team objectives. Refer to the strengths/needs list you just made. Record the group consensus below. Finish this task in 5-10 minutes.

TEAM OBJECTIVES

CRITIQUE

In formulating team objectives, did you consider:

learning to interact with others as members of an interdisciplinary team?

advantages of the IPP system to your agency?

advantages to yourselves?

advantages to your clients?

If these questions suggest any further objectives for your team, add them to your list now.

EXERCISE: TEAM POLICIES

Hopefully you now feel comfortable enough with each other to make some policy decisions regarding attendance, late arrival at training sessions, incomplete individual practice assignments, and make-up sessions. The purpose of setting some policies at this point is not to be threatening, but to let group members know what is expected of them by the group. You may feel a need for guidance from some authority outside your group; but try first, as an independent interdisciplinary team, to work out reasonable guidelines here. The coordinator may work at the board again; then record your consensus below.

TEAM POLICIES

Attendance _____

Late arrival _____

Incomplete individual practice assignments _____

_____

Make-up sessions _____

CONCLUSION

Your attitudes about your clients help to determine the goals and objectives you set with them and for yourselves in individual program planning. To close Session 1, listen to Dr. Marc Gold, of the University of Illinois, discussing what "making it" in society means for you and your clients. Consider his comments in light of the objectives you set for yourselves as a team.

Begin the videotape at the counter number where the previous talk ended. Turn on the TV monitor now.

" 'Making It' In Society"

Dr. Marc Gold

Approximate counter numbers 625-850
Tape 1 ends here

NOTES _____

Before meeting for Session 2, be sure to complete the individual practice assignment, printed on the next page. Each team member will work on this assignment individually.

Also, check to see that the room and equipment are reserved for Session 2. You have now finished with Tape 1; you will need only Tape 2 for the remaining sessions. Record below the information about meeting place and time for Session 2.

Session 2: Date_____ Time _____

Place _____ Coordinator _____

REVIEW: "MAKING IT" IN SOCIETY

At the beginning of Session 2, you will have a chance to discuss Dr. Gold's talk and to reset team objectives. This outline will help you review for the discussion. You do not have to read it aloud in the group.

1. How each of us makes it or doesn't make it has to do with a whole lot of things that people see and put into a balance. We weigh negative and positive things about a person and give him or her more chances if the result is a plus.

2. **The competence-deviance hypothesis:** the more competence an individual has, the more deviance is tolerated in that individual by others.

   Deviance: anything that brings negative attention. Negative attention includes doubts about a person's ability to take a part in society.

   Competence: something someone has, that not everyone has, that is wanted and needed by someone else.

3. There are three kinds of deviance.

   Developmental deviance: things you do when you are young, but which bring negative attention to an adult—for example, hotrodding. Developmental deviance is elective—that is, you can decide to do it and take the consequences, or decide not to do it.

   Private deviance: things you like doing in private but wouldn't want anyone else to know about. You don't have to balance this deviance with a competence, because people don't know about it. Private deviance, like developmental deviance, is elective.

Non-elective deviance: public deviance that you can't get rid of, such as being quadriplegic, or having cerebral palsy. These "deviances" or differences cause people to doubt your abilities and must be balanced with competencies.

4. If a person with non-elective deviancy is going to make it like everyone else, that individual must have things that are wanted, needed, and not available everywhere. These things must be perceived as more important and valuable than those things that need to be tolerated, or are difficult to understand, or are different.

5. If we teach a handicapped person to bathe, we are merely eliminating a deviancy, not giving a competency, because we expect everyone to bathe. Likewise, we are all supposed to be toilet trained, know how to use public transportation, get to work on time, and eat with a knife and fork.

6. Competence for handicapped persons, as well as for anyone else, might include:

   social skills (the ability to make people glad you are around)

   vocational skills (the ability to do jobs not everyone can do)

7. The only difference between us and severely handicapped people is that it is harder for them to arrive at a positive balance. Thus they need some marketable, usable, important, and needed skills even more than we do.

8. To help severely handicapped people make it, you must first have real convictions that they are capable of making it, and that you are capable of helping them make it.

9. You have accomplished something if you can say, "I helped him do that." But you have accomplished even more if you can say, "I helped him so that now he can do that."

INDIVIDUAL PRACTICE: PERSONAL TRAINING OBJECTIVES

1. Consider your own personal strengths and needs as a member of an interdisciplinary team. Use the guidelines presented for the exercise in preparing a team strengths/needs list. Record your strengths and needs below.

Name _____

STRENGTHS/NEEDS LIST

Strengths	Needs
_____	_____
_____	_____
_____	_____
_____	_____

2. What objectives would you as an individual like to achieve during this training? Think about what Dr. Gold's remarks on "making it" in society mean as you prepare your objectives. Record your objectives below.

PERSONAL OBJECTIVES

_____

_____

_____

_____

_____

3. In Session 2, you will meet Louis, your practice client, on videotape. In preparation for your work with Louis, read the background material on him in Appendix B before you meet for Session 2. If you want to take notes as you read this material, you may use the note paper provided at the back of this workbook.

IPP

SESSION 2: GOALS

Here is what you will do:

Critique your personal and team objectives from Session 1.

Read an overview of the four elements of an IPP.

Write a strengths/needs list for Stylish Sue.

Review the seven principles for writing meaningful goals.

Write goals for Stylish Sue.

Watch a client on videotape and develop a strengths/needs list and goals for him.

At the end of this session you will know how to:

Develop a strengths/needs list.

Write goals.

Note: Set up the video equipment.

SESSION 2

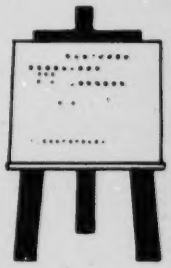
CRITIQUE: PERSONAL TRAINING OBJECTIVES

Choose one person to read the following paragraph aloud.

Begin this session by sharing the personal objectives for this training that you developed since the last group meeting. In discussing your training objectives, consider what influence Dr. Gold's videotape presentation at the end of Session 1 had on you. Did he provide any insight into different ways of looking at clients? Did the idea of creating competencies as well as eliminating deviancies seem to be a productive way of approaching training programs? Take about 10 minutes for this discussion.

CRITIQUE: TEAM TRAINING OBJECTIVES

Rotate to the next person to read the following paragraphs.



In light of your discussion of personal objectives, do you feel a need to modify and/or add to the team training objectives you formulated in Session 1? Take a minute now to review them.

You might find it helpful to have the Session 2 coordinator write the suggested modifications on the blackboard (or large paper pad) so that the whole group can see them. Any that the group agrees upon should be recorded below.

REVIEW: SESSION 1

Continue to take turns reading aloud.

In the first session you watched a videotape overview of individual program plans and learned that they are written program plans which have four basic parts:

GOALS

OBJECTIVES

STRATEGIES

EVALUATION

Goals, which are vague and usually subjective, define the general direction of the client's program plan. "Improve interpersonal relations" is the example Dr. Parham used in the tape.

Once the goals are formulated, **objectives**, or smaller steps toward reaching the goals, are developed. Objectives are more precise than goals; they tell exactly what the client will do when training is complete. A good objective for the goal "improve interpersonal relations" might be: "The client will go on his own to three consecutive Friday evening parties by the end of a 3-month period."

In order to achieve the objectives, it is necessary to move on to **strategies**, the third part of the individual program plan. Strategies tell *who* will do the training, *when* or how often it will be done and *how* it will be done. One strategy for getting a client to go to parties unattended might be to have a friend or well-liked supervisor accompany him or her to the first few gatherings.

The final part of the IPP, **evaluation**, is simply a means of monitoring the progress of the plan. That is, by recording data during each training session, you can check to see that the strategies are producing the desired changes in behavior that the objectives specify. For the client whose goal is improving interpersonal relations, you would check to see whether having the supervisor accompany the client (strategy) led to the client attending the socials alone within the specified 3-month period (objective).

Although it may seem a bit confusing at this point, the four parts of an IPP and their relationships to one another should become much clearer when they are discussed in more detail in future sessions.

In the second part of Session 1 you watched and reviewed a videotape presentation by Dr. Crosby on the interdisciplinary team. You learned that on an interdisciplinary team, persons of different work backgrounds work together and are free to express opinions on any aspect of a client's program. You then organized into an interdisciplinary team and set group objectives and policies.

Session 1 closed with a videotape presentation by Dr. Gold about various ways in which we might view developmentally disabled persons.

GOALS

Continue to take turns reading aloud.

From Session 1 you gained a model for developing an IPP. You know that it has four major parts and is written by an interdisciplinary team. But there are so many things you and the client could work on. How can you decide where to begin? Dr. Gold has some suggestions.

Dr. Gold's presentation is at the beginning of Tape 2. Put Tape 2 on your video playback equipment and turn on your monitor. Watch until Dr. Gold finishes talking and you see STOP *on the screen. Record the counter number where you stop.*

"Deciding What to Teach"

Dr. Marc Gold

Approximate counter numbers 000-131
*Presentation ended at counter number*_____

NOTES _____

THE STRENGTHS/NEEDS LIST

Continue to take turns reading.

Dr. Gold suggests that you need to decide what it takes for each client to "make it" in his or her own particular situation. But how can you make that decision? What can you do to get started?

You know that the first step in developing an IPP is writing GOALS. That is, you and your client decide what you want to accomplish together and you write down your intentions. But formulating goals requires some prior observation and thought.

A helpful way to begin is to define your client's strengths and needs.

It is common to talk about a client's weaknesses rather than needs, and to ignore his/her strengths altogether. But using the words *strengths* and *needs* will help you think positively about your client instead of thinking about what he/she lacks. Remember what Dr. Gold said: We can't help clients to "make it" just by eliminating their weaknesses. We must help them build on their strengths. When a client's *needs* are met, he/she will have more *strengths*.

Strengths and needs are often related. For example, being able to put shoes on the correct foot is a *strength* upon which you can build to meet the *need* of being able to tie shoes.

In formulating goals, then, begin with a strengths/needs list.

Under **strengths** list:

what the client can do

what the client likes to do

people who are willing to help

Under the **needs** state in positive terms:

what you and the client would like to accomplish

Remember to involve your clients. They are often able to supply valuable information about their own strengths and needs.

Suppose your agency has just accepted James, a 17-year-old male, for services. You have been appointed members of an interdisciplinary team assigned to James and this is your first meeting. From the case folder, you know that James is mildly retarded, has epilepsy with infrequent grand mal seizures, has normal motor skills, a moderate hearing loss and some slurring of speech. He has attended elementary school and has shown signs of withdrawal.

One of you talked with James before this meeting. He told you that he is interested in mechanical work and that he likes to put gadgets together. He also likes Sue (another client) and his favorite pastime is fishing. He is especially fond of his younger brother, who has been willing to help him with some basic reading skills. James lives with his family (mother, father, and one brother); he thinks they are interested in him and would like to see him get a job as soon as possible.

When you approach clients positively by asking what they can do, what they like to do and who they like, they will be willing to tell you much about themselves that you might not otherwise learn. And this information is often the most helpful.

Your strengths/needs list for James might look something like this:

STRENGTHS/NEEDS LIST

CLIENT *James*

Strengths	Needs
What the client can do, what he likes to do, people who are willing to help.	What you and the client would like to accomplish.
1. James's motor skills are normal.	1. James needs to learn a skill that will allow him to find employment.
2. James is interested in mechanical work.	
3. James can carry on an adult conversation.	2. James needs some speech therapy.
4. James is fond of his younger brother and has developed a new friend here.	3. James needs to become more outgoing.
5. James likes to go fishing.	
6. James's parents are interested in his welfare.	

From this list you can see that, in most cases, James's strengths and needs are related. For example, his motor skills and interest in mechanical work (strengths) can be used in helping him develop an employable skill (need). When you determine what strengths a client has that may be used to meet his needs—and state those needs in positive terms—developing an effective IPP becomes an easier task.

How Do You Determine A Client's Strengths And Needs?

1. **Ask the client.**

   If clients have verbal skills, they can tell you a lot about what they can do, what they would like to do, and whom they like and trust.

   Your client knows best!

   If you know what your clients want to learn, you know what they are motivated to learn. Even non-verbal clients can tell you much about themselves by their behavior.

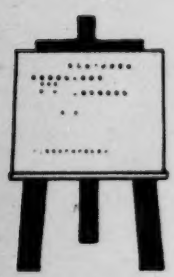
2. **Ask people who are significantly involved with the client.**

   Family, friends, teachers and rehabilitationists who have worked with the client before all have important information to give you. You may find their subjective evaluations more useful than test scores.

3. **Observe.**

   Your own observation should provide information about your client's strengths and needs, even if you have known him or her for only a short time.

EXERCISE: STRENGTHS/NEEDS LIST FOR STYLISH SUE



This is Stylish Sue, another one of your clients. Discuss her strengths and needs as an interdisciplinary team. (You may find it helpful to have the session coordinator write any suggestions on the blackboard or easel before recording the group's decisions below.) Don't be afraid to make assumptions about Sue if you feel the picture supports your ideas. Take about 5 minutes to do this exercise.

STRENGTHS/NEEDS LIST

CLIENT Stylish Sue

Strengths	Needs

CRITIQUE

What kinds of things should you include on a "strengths" list?

1. _____
2. _____
3. _____

What should you include on the "needs" list?

_____

Refer back to page 34 to check your answers. Then use your list to make any necessary improvements in Stylish Sue's strengths/needs list.

GUIDELINES FOR WRITING GOALS

Developing a strengths/needs list for your client will help you determine the general direction of the program and the areas in which you will want to develop goals. Here are some principles to keep in mind when formulating those goals.

1. State your goals in positive language.

Using positive language will help you aim at creating new behaviors rather than simply eliminating old ones. "Learn appropriate table manners" makes a better goal, for example, than "Keep client from making a mess at the table." If you aim no higher than eliminating deviant behaviors, your client might soon be left with no behavior at all! As you concentrate on developing positive, new behaviors, the old, negative ones will disappear.

EXERCISE: POSITIVE LANGUAGE

Below is a list of goals which are not related to any specific clients. As a group, decide which are suitable for an IPP because they use positive language. Circle them. In the blank space on the next page rewrite the goals you felt were not suitable. Take about 10 minutes.

1. Keep client from breaking things.
2. Teach proper toilet behavior.
3. Eliminate inappropriate gestures.
4. Teach client not to cuss.
5. Improve ability to manage money.
6. Stop client from hugging and kissing all members of the opposite sex.
7. Teach client to dress him/herself.
8. Develop employable work skills.
9. Eliminate pouting.
10. Prevent client from kicking his/her roommate.

Goal Revisions _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

CRITIQUE

Numbers 1, 3, 4, 6, 9 and 10 all use negative language and should have been improved. If you skipped any of these, or rewrote any of the positive goals, discuss your reasons for each decision. Try to determine why you were incorrect and make any necessary revisions.

Take turns reading aloud.

The first, and one of the most important, general principles of developing effective goals is using positive language. Other important considerations are:

2. Create competencies as well as eliminate deviances.

As Dr. Gold pointed out in his videotape presentation earlier, self-help skills—such as toileting, dressing and feeding—are important, but goals aimed at creating competencies should also be included. Relating well to others and a highly marketable job skill, for example, might both be considered competencies; that is, they are abilities that most people want and need but not everyone has. Vocational competency is especially important to developmentally disabled people, for it offers them a degree of independence not guaranteed by self-help skills alone and does much to compensate for those things about them that bring negative attention but cannot be eliminated.

3. **Limit your goals to two or three at a time.**

   Once you have developed a comprehensive strengths/needs list, you could probably write many, many goals for your client. But if you try to work on too many areas at once you may only confuse yourselves and your client. So it is helpful to rank the goals you have developed. That is, you should choose, as an interdisciplinary team, the two or three goals you consider most important for the client to "make it" in society.

4. **Take into account the sequence of development.**

   In ranking, you must also consider which goals, of necessity, must come before other goals. If you want a client to learn appropriate verbal responses, for example, you must first make certain that he has an adequate vocabulary. Many behaviors are learned in sequence. Before learning to eat with a spoon, you learned to grasp objects.

5. **Include both short- and long-range goals.**

   Long-range goals are necessary in that they indicate what the program plan will eventually accomplish, but these goals may often take years to reach. If there are no short-range goals included in the plan, progress is not as easy to check and you and your client may become discouraged.

6. **Be realistic.**

   The goals you and your client set should be reasonable. For example, since James has a slight hearing loss, you would not try to train him for a job that requires an acute sense of hearing (unless, of course, his hearing could be mechanically or surgically restored).

7. **Make your goals understandable.**

   Your goals should be understandable and important to the client, the staff who implement the training, parents, guardians and any others who will be involved significantly in helping the client achieve the goal. When possible, let these people be actively involved in setting the goals. Making your goals understandable and important to them is the first step in gaining their cooperation.

EXERCISE: GUIDELINES FOR WRITING MEANINGFUL GOALS

As a group, try to recall as many of the seven principles for writing goals as you can. Record your answers below.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

CRITIQUE

If there were any you could not remember, refer back to pages 38-40.

EXERCISE: GOALS FOR STYLISH SUE

Using the seven principles listed above and the strengths/needs list already on page 37, agree upon at least one—but no more than three—goals for Sue. Do this as an interdisciplinary team and take about 10 minutes.

GOALS

CLIENT Stylish Sue

_____

_____

_____

_____

If you would like to take a break, now would be a good time to do so.

APPLICATION: DEVELOPING A STRENGTHS/NEEDS LIST AND GOALS FOR LOUIS

The videotape you are about to watch show Louis with the recreation supervisor and in the lunchroom. As you watch the tape, you may notice that the staff persons working with Louis do not always act appropriately. While you may want to comment on what they did well and what they could have done better, concentrate on Louis's behavior. Try to spot his strengths and needs and think of the goals you would like him to achieve.

Turn on the videotape at the counter number where the last presentation ended. When this presentation ends, record the counter number below.

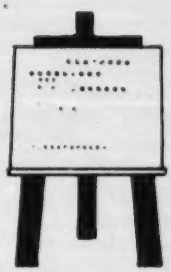
"Louis"

Approximate counter numbers 139-239
Presentation ended at counter number _____

NOTES _____

You are an interdisciplinary team for Louis. Based on the videotape and the background information in the appendix, write a strengths/needs list for him.

Take about 15 minutes to complete this exercise.



STRENGTHS/NEEDS LIST

CLIENT Louis

Strengths	Needs

CRITIQUE

If you need a reminder about what kind of things to include on the list, refer to page 34. Record the information below and make any necessary revisions in the list you just developed for Louis.

Strengths _____

_____

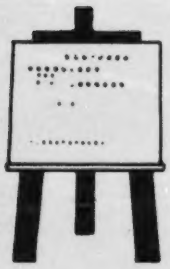
_____

_____

Needs _____

Using the strengths/needs list as a guide, discuss possible goals for Louis. List at least three goals that you, as a group, can agree upon for him. Take about 10 minutes.

GOALS



CLIENT Louis

1. _____

2. _____

3. _____

CRITIQUE

Now critique your goals using the criteria listed on pages 38-40. Make any necessary revisions below.

GOAL REVISIONS

1. _____

2. _____

3. _____

EXERCISE: TEAM ORGANIZATION REVIEW

Throughout Sessions 3, 4, and 5 of this training, you will continue working on an IPP for Louis. Based on your observations of his behavior, the background information in the appendix and the experience you just had writing goals for him, would you say that your team is appropriately organized to meet his needs? Does it include all direct care people who would have contact with Louis? If not, go back to the Team Organization Form in Session 1 and make the necessary revisions.

Will you need to consult any specialists at your next interdisciplinary team meeting? If so, indicate below which ones would be helpful.

_____

_____

Since this is a training exercise, you may not actually wish to contact the consultants you need, but take a few minutes to discuss how you might go about consulting with them. Record that information below.

_____

_____

_____

DISCUSSION: TEAM PROCESS

Now set your workbooks aside for 5 to 10 minutes and consider the group processes that have occurred during this session. How did your responsibilities as individual team members overlap? How did the group arrive at a consensus? Was this procedure effective in developing strengths/needs lists and goals?

You have now completed Session 2. Before meeting for Session 3, be sure to complete the individual practice assignment on developing a strengths/needs list and a goal for Active Andy.

Also, check to see that the room is reserved for Session 3. Record below the information about meeting place and time for Session 3.

Session 3: Date_____ **Time** _____

Place_____ **Coordinator**_____

INDIVIDUAL PRACTICE: A STRENGTHS/NEEDS LIST AND A GOAL FOR ACTIVE ANDY

Before your group meets again for Session 3, each of you should individually complete the following exercise.

Active Andy (pictured on this page) is engaged in several different, specific behaviors. Develop a ***strengths/needs list*** *for him; then write* ***one overall goal*** *that you think would apply to all these situations.*

Use the work space on the next page.

STRENGTHS/NEEDS LIST

CLIENT Active Andy

Strengths	Needs

GOAL _____

CRITIQUE

Critique your goal according to the criteria on pages 38-40. (Note: Because you are only asked to write ***one*** *goal for the purpose of this exercise, principles 3 and 5 will not apply.) Make any necessary revisions below.*

_____

_____

_____

SESSION 3: OBJECTIVES

Here is what you will do:

As a group, critique the goals you have written individually for Active Andy and select one to work on further.

Watch videotape presentation on pinpointing behavior.

Read workbook introduction to objectives and complete the exercises.

Watch the videotape of the client, Louis.

Develop two objectives for Louis, corresponding to the goal you wrote in Session 2.

At the end of this session you will know how to:

Pinpoint behavior.

Write objectives.

Note: Set up the video equipment.

SESSION 3

CRITIQUE: A STRENGTHS/NEEDS LIST AND A GOAL FOR ACTIVE ANDY

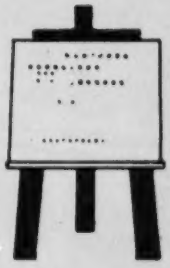
Choose one person to read the following paragraphs.

You have all had time now to observe Active Andy individually as he was pictured in three settings, and to begin on your own to formulate a strengths/needs list and some goals for him.

Now, as an interdisciplinary team, share your observations of Andy; reach an agreement on his strengths and needs and on a goal for him. Try to finish this interdisciplinary team meeting on Andy in about 15 minutes, following the directions below.

The coordinator for Session 3 should go to the blackboard or easel to make notes as each group member reads one of the strengths and corresponding needs from the list he or she has made. Group members should continue to suggest additional strengths and needs until you agree that you have a satisfactory strengths/needs list for Andy.

Then, using the same procedure, share the goals you have written individually for Andy. Critique the goals using the criteria you wrote down on page 41.



As a group, agree on one goal for Active Andy that you would like to work on further. Make sure it meets all the criteria set for goals.

When you have decided together on a goal, write it here for future reference:

_____

_____

PINPOINTING BEHAVIOR

Continue to read aloud and to rotate readers.

You probably would have had little difficulty writing a goal for Stylish Sue, because you saw only one aspect of her behavior (how she dresses) and that behavior was well-defined.

It may have been harder to write goals for Louis and Active Andy, but even their behavior was given some limits by the camera and artist's pen.

With most of your clients, you deal with behavior that is vague, changing, and hard to define. That is why **goals** are an important part of an IPP. Goals let you establish some general guidelines for treatment without requiring that you be too precise. When you are just beginning to write an IPP, it is helpful to be able to write about behavior that may seem indefinite in the vague language of goals.

The general statements of goals have limited usefulness, because they don't tell you exactly what you want your client to *do*. And, until you precisely define client behavior, you will find it difficult to specify how you want that behavior to change. Thus, **objectives** are a necessary part of an IPP. When you write objectives, you move away from goals or general statements of program intentions, to a specific definition of the behavior you want your client to display when training is completed.

As you learned in Session 2, making up a strengths/needs list helps you prepare goals with your client because it draws your attention to specific characteristics of your client.

Likewise, an important first step in setting *objectives* for your client is **pinpointing behavior**. Pinpointing behavior means defining specifically what a client *does*. It means that instead of describing a client as "helpless" (a vague term), you note that the client needs to be able to eat with a spoon and walk alone. Pinpointing behavior in this way will help you write objectives, which must describe the behavior you want your client to display.

Dr. James Kopp, of the University of Texas at Arlington, has recorded for you on videotape some of his ideas on how to pinpoint behavior.

Put Tape 2 on your video playback equipment. Set the tape at counter number 000.

Turn the tape forward to the counter number where the taped behavior of Louis ended (you recorded this number near the end of Session 2).

Turn on the monitor and watch until Dr. Kopp finishes speaking and you see

on the screen.

Record the counter number where the presentation ends.

"Pinpointing Behavior"

Dr. James Kopp

Approximate counter numbers 246-514
Presentation ended at counter number _____

NOTES _____

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REVIEW: PINPOINTING BEHAVIOR

Take turns reading this review aloud. Pause during your reading, if you wish, to share questions and comments.

1. **The behavioral approach to persons with disabilities is useful because it allows us to do something about meeting their needs.**
2. **Before we can actually help a person meet his/her needs, however, we must define the need specifically.**

   For example, John has been diagnosed as autistic. To be more specific, one might say that John is withdrawn, non-communicative, disruptive, helpless and aggressive.

   A legitimate goal in an IPP for John would be, "Improve John's communication skills."

3. Once a goal is agreed upon, you need to talk about a *discrete behavior*. Discrete behavior is behavior that occurs over a short period of time, is observable to you and everyone else, and can therefore be measured.

   If you have described John as "non-communicative," you must specify the discrete behaviors that "non-communicative" describes. John displays the following behaviors:

   He avoids eye contact.
   He won't follow verbal prompts.
   He makes no vocal sounds.
   He won't imitate.

4. Pinpointing behavior means specifying aspects of the behavioral goal that could be pursued as part of the program plan.

   You can't put together a program with adjectives like *non-communicative*. But you can work with discrete behaviors, such as *not following verbal prompts*.

5. Once you have defined a discrete behavior that you want to work on in a program, you measure it.

   For example, when 10 different verbal prompts are given to John at 30-second intervals during a 15-minute training period, he responds to only 2 of them.

6. You frame your objectives in your IPP around the discrete behavior you have pinpointed.

   Thus, you might aim for John to respond to verbal prompts at a proficiency level of 90% for three successive daily sessions.

   As you can see, this is much more specific than the goal, "Improve John's communication skills."

   The reason for being so specific is that you could now develop a workable program for John. You could *do* something about John's poor communication skills.

QUESTIONS AND DISCUSSION: PINPOINTING BEHAVIOR

How can you avoid using negative words in goals and objectives when you are so often trying to extinguish a negative behavior?

Frequently you can turn around a negative description of behavior into a positive goal or objective. For example, instead of aiming to prevent a client from throwing food, you can help him/her learn to eat with a spoon. Think in these terms: if a client were *not* displaying a negative behavior, such as throwing food, what positive behavior might he/she be displaying?

Positive language is important in a program plan. We tend to respond to non-cooperative behavior with punishment. Positive goals and objectives encourage the teacher or trainer to prefer rewards to punishment, and to prefer training to maintaining the status quo.

When a client throws food at the table, should you work to eliminate throwing food before you teach spoon feeding?

Individual program planning requires that you determine prerequisite behavior, or fundamental behavior that a client must learn before mastering the behavior that is ultimately desirable. It would be difficult to put a person in a spoon-feeding program who could not sit upright or grasp a spoon. So you would work on those behaviors first.

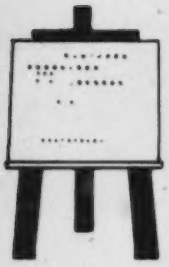
If a client is throwing food, you might work to get him/her to sit quietly with spoon in hand before you actually work on feeding. But frequently, if you work to increase positive behavior, such as spoon feeding, the negative behavior, throwing food, will decrease automatically.

What if you're wrong? What if you're working on spoon feeding and the client continues to throw food?

Then you must note that you're wrong!

An IPP is not fixed and unchanging. In fact, an IPP must be revised as situations and needs change. More often than not, after writing an IPP and then trying it, you run back to the drawing board and redo it.

If you are working on spoon feeding and the client's food throwing continues to interfere with training, go back and write into your plan specific procedures for handling food throwing.



EXERCISE: PINPOINTING BEHAVIOR

As a team, think of three to five examples of discrete behavior that each of the following adjectives could refer to. (Discrete behavior is defined in the review of the tape.) Let the team coordinator for Session 3 go to the blackboard or easel to make notes while you discuss possible examples of discrete behavior. Then record the examples that the group agrees on in the space provided below. Finish this exercise in 10 minutes.

General Behavior	Discrete Behaviors
1. withdrawn	1. avoids eye contact with other people 2. does not follow verbal prompts 3. sits alone in a corner
2. aggressive	1. _____ 2. _____ 3. _____ 4. _____ 5. _____
3. shy	1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Now that you can pinpoint behavior, you are ready to develop the second part of an IPP, objectives.

OBJECTIVES

Objectives and **goals** provide different kinds of guidelines for the staff and client. Goals state in general terms where you are going; they help you get started with your plan. Objectives tell in behavioral terms exactly what you want your client to **DO** when he completes this segment of this training.

Example:

Goal: Client will be able to adhere to a schedule.
Objective: Within 6 weeks, client will state the time of day correctly to the minute when asked.

The **goal** states the general direction of the program, but it does not indicate specifically what the client's behavior will be, nor when he/she will master the behavior.

The **objective** is:

behavioral (it describes behavior that you can observe and measure)

outcome-oriented (it tells what the client's behavior will be at the *end* of the training)

time-linked (it tells how long it will take the client to learn the behavior)

Behavioral means that the objective specifies behavior that is observable and measurable.

Observable behavior is behavior that you can point at. It is behavior you recognize by using your senses of seeing and hearing. It is an action or a performance. Concepts and value judgments are not observable.

You can't observe "personal hygiene," but you can observe whether a person bathes and uses soap. Thus, if you were writing an objective for the goal of improving personal hygiene, you would refer to behavior that you could observe, such as whether a person bathes and uses soap.

Measurable behavior is behavior that you can count. You can count *how often* measurable behavior occurs, or *how long* a person does a task, or *how much* he is producing.

You can't measure "physical stamina" until you express that concept in terms of what you expect a person with physical stamina to DO. Thus to write an objective that is measurable, you translate the goal "Improve physical stamina" into:

A. Walk 20 minutes without stopping for rest.
(This tells *how long*.)

B. Do five push-ups in 1 minute.
(This tells *how long* and *how much*.)

C. Swim ½ hour every day.
(This tells *how long* and *how often*.)

The key to writing a successful IPP is to specify behavior that is observable and measurable when you write your objectives. Then you know exactly what you want your client to do, which will enable you to set up criteria for determining when the training has succeeded.

EXERCISE: OBSERVABLE AND MEASURABLE BEHAVIOR

*As a team, discuss the behaviors on the list below and indicate those that are **observable** and **measurable** by marking them with an "X." In order to get the maximum value of this exercise, complete it without reading ahead in the workbook.*

_____ 1. understand promptness

_____ 2. scrub the sink each Friday

_____ 3. say "thank you" when offered a piece of cake

_____ 4. act cooperatively

_____ 5. share in household tasks

_____ 6. work productively

_____ 7. arrive at work on time

_____ 8. put one's shoes on the proper feet

_____ 9. be polite

_____10. lift a 5-pound weight

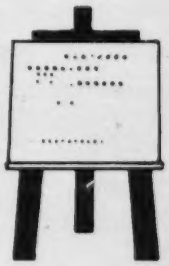
Scrubbing the sink each Friday, saying "thank you" when offered a piece of cake, arriving at work on time, putting one's shoes on the proper feet, and lifting a 5-pound weight are all observable and measurable behaviors.

You can observe with your senses of seeing and/or hearing a person doing these things.

You can count how often each occurs.

Understanding promptness, acting cooperatively, sharing in household tasks, working productively, and being polite, on the other hand, have to be judged subjectively. They would not make good objectives because they cannot easily be observed and measured.

As a group, specify an observable and measurable behavior for each of these five concepts. The coordinator's notes at the blackboard or easel can help the group reach an agreement. Then record the group consensus below. Take 5-10 minutes to do this.



1. understand promptness _____
2. act cooperatively _____
3. share in household tasks _____
4. work productively _____
5. be polite _____

CRITIQUE

Ask yourself the following questions about each of the behaviors you have written down:

1. Could you observe this behavior by seeing and/or hearing?
2. Could you point at this behavior?
3. Could you count how often this behavior occurs?

If you answered "yes" to the questions, you have described behavior that is observable and measurable.

If you specify measurable and observable behavior in your objectives, you are using behavioral terms. That is, you are telling what you want your client to DO.

If you define exactly what you want the client to DO, you can communicate that objective to him/her, to significant others and to members of the staff without confusion.

In addition to being behavioral, objectives are **outcome-oriented.** Outcome-oriented means that your objectives state what the client's behavior will be when the training has been completed.

Avoid the word *learn* when you write objectives. If you use the word *learn,* you are probably describing a *process, not an outcome.* Objectives are outcome-oriented because they describe the client's behavior as it is to be performed after training has taken place.

WRONG: Within 6 weeks, client will *learn to state* time of day correctly.
(This is not an outcome-oriented objective because it does not tell what the client *will do* when training is completed.)

RIGHT: Within 6 weeks, client *will state* the time of day correctly *to the minute when asked.*

(This is an outcome-oriented objective because it describes the client's behavior as it will be when training is completed.)

You must determine how well you expect the client to perform when training is completed. You can specify how often he/she will exhibit a behavior by indicating a percentage of times that a client will respond correctly, or by referring to the time of the day or week that he/she will perform the desired task and under what circumstances. This performance information is referred to as *criterion.* The criterion you establish lets you determine when the client has learned the behavior up to the level of performance required.

Example 1: Within 4 weeks, when the recreation director calls John's name at 10-minute intervals, John will make eye contact with him *three out of five times.*

(The criterion here is three out of five times. This level of performance is satisfactory and normal for eye contact in a gym setting.)

Example 2: Within 3 weeks, the client will take a bath unassisted *every other day.*

(The criterion here, every other day, is about normal. This criterion might change depending on environmental circumstances. A hot, humid summer would call for more baths than a cool, dry winter!)

Thus, an outcome-oriented objective names the behavior the client will exhibit when training has been completed, and indicates the level of performance required at that time.

Objectives are behavioral, outcome-oriented, and also **time-linked**. Time-linked objectives indicate how long it will take your client to learn the behavior.

Example: *Within 6 weeks,* client will state the time of day correctly to the minute when asked.

(The target date of 6 weeks indicates how long the trainer thinks it will take to help the client to master stating the time of day correctly.)

You pick target dates for completing an objective on the basis of the behavior to be learned, your client's skill, and the amount of time available for training. A short-term objective might require only a few training sessions, while a long-term objective could require several months or more of training.

The target date is only an estimate, but it does serve as a commitment for you and your client to accomplish something in a given period. If the client masters the task in less time than you have estimated, there is no reason for training on that task to continue. If the target date passes and the task still has not been learned, you would evaluate your program to see whether you had simply underestimated the time required for training, or whether the training methods needed revision.

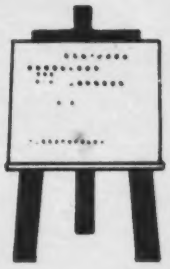
EXERCISE: TIME-LINKED, OUTCOME-ORIENTED OBJECTIVES

Assume that your interdisciplinary team has written the following objective for Stylish Sue:

Stylish Sue will put each shoe on the correct foot.

That is a good objective in that it specifies an observable and measurable behavior, putting on shoes, and it does indicate a behavior that Sue will exhibit at the outcome of training.

But it is an incomplete objective; you need to specify how long it will take Stylish Sue to master putting on her shoes. And before the objective totally meets the test of being outcome-oriented, you must specify the level of performance (criterion) you expect Sue to reach when training is completed.



Discuss as a group how you can include the target date and criterion in the objective. Then write the objective your group agrees on in the space below.

_____

_____

The objective, as you have written it, meets three criteria of a good objective. It is:

1. _____
2. _____
3. _____

1. behavioral 2. outcome-oriented 3. time-linked

Objectives are generally different from goals in three ways:

Objectives describe observable, measurable behavior.

Objectives are outcome-oriented.

Objectives are time-linked.

Objectives are like goals in these ways:

They emphasize competency, not deviancy.

They are written in positive language.

They reflect sequential and progressive behavior.

They are realistic.

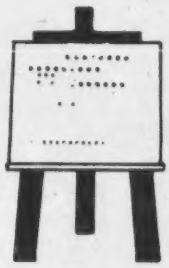
They are understandable to staff and client.

GOALS	OBJECTIVES
Show general intent and direction of the IPP.	Specify what the client's behavior will be at the end of the training period, and indicate time limits.
Client will show more consideration for others.	Within 2 weeks, client will let his roommate choose the television programs on Tuesdays and Thursdays.
Client will become more independent.	Within 2 months, client will ride on the bus by herself to get to work each day on time.

EXERCISE: WRITING OBJECTIVES

Here is a chance for group members to practice together breaking down some goals into objectives. For each goal listed below, develop an objective and write it down in the space provided. The blackboard may help involve everyone in the discussion, but write the group consensus in the space below for future reference.

Goal	Objective
1. Increase attention span in the classroom.	
2. Learn to relate positively to others during recreation.	
3. Improve housekeeping habits.	
4. Develop good work habits.	
5. Develop greater self-confidence.	
6. Learn a marketable job skill.	



CRITIQUE

Now critique each of the objectives you have just written, asking the following questions about them.

1. Does the objective express behavior that is observable and measurable—that is, an action or a performance?
2. Does the objective describe what the client's behavior will be when training is completed?
3. Have you specified a criterion for learning that indicates how often and/or how long the client will persist at the desired behavior and under what circumstances?
4. Have you set a target date for the client to master the behavior?
5. Have you emphasized competency, not deviancy?
6. Is the objective stated positively?
7. Have you taken into account prerequisite behavior?
8. Is the objective realistic according to your client's abilities, and understandable both to the client and to significant others? (To answer this question, you will have to imagine what clients might be like. The question is included on this list because it is important for you to ask it when you have real clients.)

Make any necessary revisions in your objectives.

If you would like to take 5-minute break before going on with this session, this would be a good time to do so.

APPLICATION: WRITING OBJECTIVES FOR LOUIS

Watch Louis's behavior on videotape again. This is a repeat of the tape you saw earlier. As you observe Louis this time, try to remember what you have learned about pinpointing behavior. After you have finished watching the tape, you will be writing objectives for the goal you wrote during the last session. Take notes so that you can refer to specific information as you prepare objectives.

Turn on your video equipment now and watch the tape of Louis.

"Louis"

Approximate counter numbers 519-582
Presentation ended at counter number _____

NOTES _____

_____

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_____

Take a few minutes to discuss what you have observed about Louis this time that you may have missed at your previous viewing of the tape. In the space below, record any additional observations that you think might be helpful to you when you write your objectives.

NOTES _____

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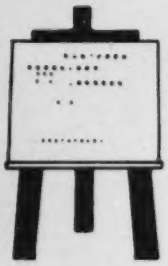
On this page, record the goal that you agreed upon for Louis at the end of Session 2. Then, as a group, write two objectives for that goal. Indicate the order in which you will pursue the objectives you have written, or whether you will pursue them simultaneously. Using the coordinator at the blackboard or easel will help you focus your group discussion, but record the objectives you agree on below for future reference.



OBJECTIVES

CLIENT Louis

GOAL _____

OBJECTIVES _____

CRITIQUE

From now on you should always critique your objectives without a reminder.

Think: measurable, observable
outcome-oriented
time limits
client's competency
positive
sequential development
realistic, understandable

Make any necessary revisions in your objectives.

Remember: You may not achieve the goal entirely with one or two objectives. But the objectives will indicate the first steps you will be taking towards reaching the goal.

HOW IS YOUR INTERDISCIPLINARY TEAM WORKING?

	yes	no
Is there still sufficient breadth, depth and variety of roles among team members to meet your clients' needs and to perform the tasks assigned in the training program?		
Does each team member feel free to share his/her thoughts on any subject, regardless of the professional discipline or job title the team member might hold?		
Does each team member have the chance to make a positive contribution to the discussions and to the decision making?		
Are all team members contributing more or less equally to the tasks you have been assigned so far?		
Are you taking the *team approach* to problem solving?		

If your answer to any of these questions is no, or even a qualified yes, take a few minutes now to discuss how you can make your interdisciplinary team work better. Discuss any disagreement among various team members about the answers to these questions. Try to work through any problems you may be having as a team.

You have now completed Session 3. Before meeting for Session 4, be sure to complete the individual practice assignment on developing objectives for Active Andy.

Also, check to see that the room is reserved for Session 4. Record below the information about meeting place and time for Session 4.

Session 4: Date_____ Time _____

Place _____ Coordinator _____

INDIVIDUAL PRACTICE: OBJECTIVES FOR ACTIVE ANDY

Before your group meets for Session 4, each member should independently complete the individual practice assignment.

Record here the goal your group selected for Active Andy at the beginning of this session (page 51). Write as many objectives for that goal as you can think of. The checklist of criteria for writing objectives on page 64 will help you judge whether you are writing your objectives correctly. Then select your three best objectives to share with the group at the beginning of Session 4.

OBJECTIVES

CLIENT Active Andy

GOAL _____

OBJECTIVES _____

_____

_____

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SESSION 4: STRATEGIES

Here is what you will do:

As a group, critique the objectives you have written individually for Active Andy.

Study the major steps involved in developing strategies.

Write a strategy for reaching one of the objectives set for the videotape client, Louis, in Session 3.

Test your strategy by role-playing the client and the trainer.

At the end of this session you will know how to:

Develop a strategy.

Note: You will not need the video equipment for this session.

SESSION 4

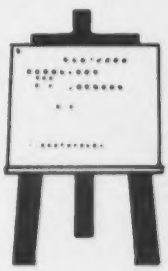
CRITIQUE: OBJECTIVES FOR ACTIVE ANDY

Choose one person to read aloud.

During previous individual practice sessions you developed and critiqued a strengths/needs list and goals for Active Andy. Now share the objectives you formulated as individuals after Session 3.

You might begin by letting one group member read his or her objectives and then discussing them as a group while the coordinator for this session makes notes at the blackboard or easel. Proceed around the group adding to the list, keeping in mind that you must choose three objectives that best fit the criteria set in Session 3 (refer back to page 64 if necessary). Take about 10 minutes for this exercise and record the group's selections below for future reference.

OBJECTIVES



CLIENT Active Andy

GOAL (from Session 3) _____

OBJECTIVES: 1. _____

_____

_____

2. _____

_____

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_____

3. _____

_____

_____

_____

IPP

STRATEGIES

Continue rotating reading.

As you learned in Sessions 2 and 3, goals give the general direction for an IPP while objectives are more precise statements of what the client's behavior will be when training is complete.

When you develop the third part of an individual program plan—**strategies**—you become even more specific than when writing objectives. Strategies are the action part of an IPP; they tell you and the client what must be done to accomplish an objective.

Strategies state WHO will do the training,

WHEN it will be done,

HOW it will be done.

Below are sample goals, objectives, and strategies.

GOAL	OBJECTIVE	STRATEGY
Shows general intention and direction of IPP.	Specifies what the client's behavior will be at the end of the training period.	States who, when, and how to meet the objective.
Client will show more consideration for others.	Within 2 weeks, client will let his roommate choose the television programs on Tuesday and Thursday.	The evening ward monitor will check at 7:00 p.m. with client and his roommate. If on Tuesday and Thursday client has allowed his roommate to select the television programs, the ward monitor will grant 1 extra hour viewing time. But if he has not, client will not be permitted to view any television that evening.
Client will become more independent.	Within 2 months, client will ride the bus by herself to get to work each day on time.	Mr. Garcia will break the task down into small steps. Each morning he will accompany the client on the bus to her job. He will go the entire way with her on the first day. The next day he will let her complete the final step of the journey by herself. On the third day, the client will complete the final two steps, and so forth, until she can proceed through the entire trip by herself.

In arriving at strategies such as those on the previous page, you will make some plans that are far more detailed than the example shows. Planning *how* training will be done includes decisions about:

method of doing the task

steps in the task

technique of presenting the task

trainer assistance

These detailed plans help you know exactly what to do when you are working with a client.

During this session, you will develop a strategy for accomplishing one of the objectives you set for Louis in Session 3. This workbook will show you, one step at a time, how to complete each part of the strategy.

On page 89, there is a form on which you will complete the strategy.

Remove page 89 from your workbook and look it over briefly.

The form includes space to indicate the main parts of the strategy—who, when, and how. It also includes places for the detailed plans you make when deciding how the training will be done.

Throughout this session, the workbook will give specific directions about what to write on the form and when to do so. Leave the form out of the workbook as you work so that you won't have to flip pages back and forth. When the session and the strategy are completed, put the page back in the proper place in the workbook. It will then serve as an example of a complete strategy.

Refer back to page 66, where you recorded your goal and objectives for Louis. As a group, pick one objective to use for developing a strategy. If possible, select an objective that can be achieved by being learned in small steps. (For example, brushing your teeth involves the smaller steps of grasping the toothbrush, squeezing the toothpaste tube, replacing the cap, and so forth.)

Write down the goal and the objective you have selected on the IPP form on page 89.

BARRIERS AND SOLUTIONS

Before making specific decisions about when and how this objective will be accomplished, and who will direct the training, it is a good idea to consider possible **barriers** that might interfere with the achievement of the objective and possible **solutions** to these barriers. Barriers might include needs for prerequisite training (in which case you would probably write a new objective and strategy to meet this need); or barriers could be problems with transportation, scheduling, space, or personnel, or the need to gain the cooperation of people who will be involved in the training.

The strengths/needs list is a good source for identifying both barriers and solutions.

Example:

> In an effort to help James acquire a skill that will make him employable, his interdisciplinary team has set an objective for him to attend a 6-week training course in beginning electronics at Alloy Company. However, Alloy is 4 miles away, and James does not drive, nor is public transportation available. By reviewing James's strengths, the team notes his parents' interest in him. They consult the parents for ideas. The parents provide the solution by arranging for a friend to drop James off at the shop on her way to work.

Review the objective you selected for Louis and recorded on page 89. As a team, consider whether there will be any barriers to achieving the objective. Record those barriers on page 89. Then, looking again at Louis's strengths/needs list (page 43), consider possible ways of overcoming those barriers. Write those solutions on page 89.

Now you are prepared to deal with the who, when, and how parts of a strategy.

WHO

A person is necessary to make a strategy happen. While the interdisciplinary team supervises strategy development and training, it selects an appropriate person or persons to take the main responsibility for planning and implementing the strategy. This person has contact with the client and the opportunities and ability to do the training. He/she typically serves on the interdisciplinary team and usually is already working with the client in the area to be improved, or has experience helping clients learn the kind of behavior the objective specifies. Direct care staff, as well as supervisors and professional staff, may be selected to plan and carry out the strategy. The strengths/needs list may also guide you in selecting the trainer by indicating to whom the client responds well.

The trainer may request the advice and assistance of other team members or of other persons with expertise and experience, but he/she has primary responsibility for deciding when and how the training will take place.

In general, the team provides enough support to let the trainer carry out the training without unduly restricting his/her right to formulate a strategy and modify it when necessary. The team should encourage the training effort and check its progress.

As a team, decide who among your members would be the best person(s) to work out the strategy for meeting the objective you have set for Louis. Record that person's name on page 89.

WHEN

While the team normally leaves specific decisions about the when and how portions of the strategy to the trainer, for purposes of this training in individual program planning, you will work together developing all parts of the strategy—who, when, and how.

The when portion of the strategy includes information on how often and what time a training session occurs, as well as how long it lasts. These decisions depend on such things as the behavior to be learned, the client's needs and abilities, and the trainer's available time. To encourage the client's greatest application of the training, it is good to schedule training periods for times when he/she will use the behavior after training. For example, if you are teaching a client to make a bed, try to schedule training for the period when clients are expected to make their beds. Also, it is preferable to avoid training when a client is hungry, tired, or otherwise unable to concentrate.

The interdisciplinary team can set guidelines to make sure that appropriate training is provided, but leaves scheduling to the trainer.

For example, the team might recommend that a person receive at least 3 hours of training per week in personal/social adjustment on a schedule arranged by the adjustment instructor. They check the arrangements and monitor progress during future team meetings.

Decide now on the best time for carrying out your strategy, how long the sessions should be, and how often they should take place. Record that information on page 89.

HOW

The how portion of the strategy is the longest and most complex part. There are numerous approaches to providing education and training to developmentally disabled persons, and the same approach will not always work for all clients or for all objectives. Your chances of being successful at teaching a variety of behaviors and different clients increase as you broaden your ability to use different teaching strategies.

This workbook does not begin to tell you all you could know about teaching strategies (Appendix D refers to books you can read to learn more.) But there are some general principles to follow in developing any strategy. For example, you must pick a strategy that suits the task to be learned, your own skills, and your client's strengths. Whatever strategy you pick, your training should help the client become more independent. Remember the distinction Dr. Gold makes between helping a client do something and helping a client so that he/she can do it independently.

Let's consider, one at a time, some of the basic things to think about in planning *how* to achieve an objective.

A. Method of doing the task

There are often a number of ways to perform a task or design a job.

Example:

> Most people put on a coat by slipping one arm into a sleeve, swinging the coat behind them, then reaching back, feeling for the other sleeve, and slipping the second arm into it. But for someone who has trouble with fine motor movements, such as Stylish Sue, who has spastic cerebral palsy, feeling for the sleeve opening behind one's back would be extremely difficult. She needs some way to hold the coat still while she aims for the sleeve opening.
>
> Stylish Sue might have more success at putting on a coat by first laying the coat on a table, sliding her arms through the sleeve opening in front of her, then pulling the coat up over the head and down to rest on her shoulders.
>
> This method of putting on a coat is illustrated below.

IPP

In planning the how portion of the strategy, you must first determine the best method for the client to perform the task. It's sometimes difficult to think of more than one method, especially for tasks that are simple and familiar to you. Remember, though, that the way you do something will not always be the best method for your client. In making your choice, consider any physical limitations of the client or routines that he/she will be expected to follow after training.

Think now about the task that you have planned to teach Louis. What are the various possible ways of doing that task? If possible, using pencils, paper, or other materials at hand, invent some props to demonstrate the different ways of accomplishing the task.

In the space below, briefly describe the methods you have discussed.

1. _____

_____

2. _____

_____

3. _____

_____

As a group, consider which of these methods would be most suitable for Louis. Write your choice on page 89.

B. Steps in the task

Once you have chosen the method of doing the task to be taught, the next step is to break down into small, learnable steps what the client is supposed to do.

Example:

> You might break the task of putting on a coat, using the method illustrated earlier, into the following steps:
>
> 1. Place it on the table, label facing up.
> 2. Turn the coat so that the collar end is closest to you.
> 3. Open the coat so that the sleeve openings are visible.
> 4. Hold both arms in front of you.
> 5. Aim at the sleeve openings.
> 6. Slide both arms into the sleeves.
> 7. Throw your arms straight up over your head to let the coat slip down over your arms.
> 8. Pull your arms down to your side, bringing the coat to rest on your shoulders.

The steps are numbered and described in detail. They help the trainer to understand what is involved in doing the task and to decide how much to present to the client at a time. The number of steps depends on the complexity of the task and on how readily a client learns. Steps that are too large may discourage a client, but steps that are too small might bore him/her.

Example:

> Stylish Sue is able to lay her coat in the correct position on a table in front of her and would become bored with a detailed demonstration or explanation of that step. But she finds getting her arms into the sleeves much more difficult and is frustrated when unable to do so. That step, then, could be broken down into smaller teachable units, such as:
>
> 6a. Hold left sleeve opening with right hand.
> 6b. Slip left hand into left sleeve opening up to wrist.
> 6c. Lay right hand on the table.
> 6d. Aim right hand, supported by the table, toward right sleeve opening and in up to wrist.

The best way to break down a behavior into small steps is to perform the task yourself (or watch others performing the task) and write down all the steps you can pick out.

Keeping in mind the method of doing the task you chose earlier for Louis, break the task into the proper size steps for him. Make them as detailed as necessary and keep them in sequence. The session coordinator might make notes at the blackboard or easel as other group members work out the steps by performing the task. Record on page 89 the steps in the task that the group agrees on. Note that the number of blanks on that page is arbitrary. You may need either more or fewer steps for your specific task.

C. Technique of presenting the task

When you have chosen the method of doing the task and broken it down into small steps, you then decide what technique(s) to use to present the necessary information to your client.

Examples of techniques include:

match to sample—presenting an object and having the client select one that matches from a group of objects. (This technique would be useful for teaching sorting and discrimination tasks, such as separating different sizes of screws into bins.)

oddity—having the client select from a group of objects the one that does not belong. (This technique also is useful for teaching sorting and discrimination, such as removing a spoiled piece of fruit from an assortment of fruit in good condition.)

backward chaining—teaching the last part of a task until the client knows it, then the next to the last part, and so on, until the entire task is learned. (The strategy in the example on page 74 for teaching a client to get to work on the bus uses the technique of backward chaining.)

forward chaining—teaching the first part of the task until the client knows it, then the next part along with the first part, and so on. (This concept of individual program planning is being presented to you in this workbook basically with the technique of forward chaining.)

total task presentation—having the learner perform the entire task every trial. (If you were teaching a client to bathe, you would probably have him/her complete the bath each training session.)

A trainer will often use more than one of these techniques for teaching a task. There are also many other techniques, not described here, which you can use.

Take a few minutes to discuss the best technique(s) for helping Louis learn his task. You may think of techniques other than those described briefly above. On page 90, describe the technique you have chosen.

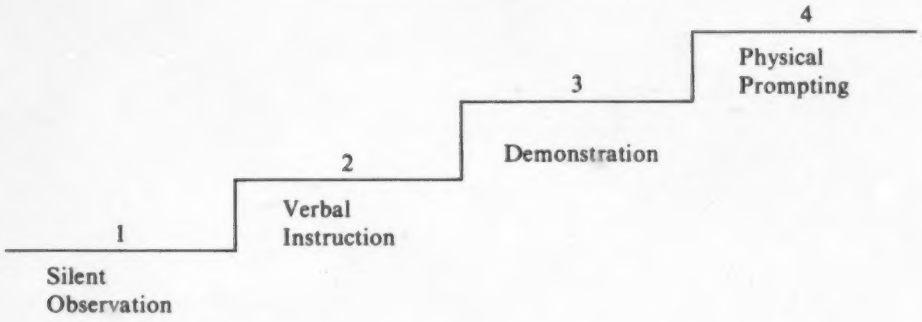
D. Trainer assistance

Once you have decided on the training technique you plan to use with a client, you will need to ask yourself more detailed questions about the training session. How will the client know what you expect him/her to do or what the job demands? And once you have communicated your expectations, how will the client know when he/she is doing the task correctly?

There are several **levels of communication** you can use to let the client know about the task and what you expect. The highest level—that is, the one that involves the most time and effort by the trainer and gives the client the most information—is **physical prompting** (actually guiding the client's limbs or other parts of the body through the steps of the task). **Demonstration** of a task provides less assistance and information than physical prompting; **verbal instruction** provides even less. **Silent observation**, the lowest level of communication, is effective only if the client knows you are watching and will respond with corrections when necessary. If you are going to use silent observation, you need to begin with at least a brief instruction, such as, "Sue, I want you to put on your coat." But then you remain silent while she tries.

The four ways of communicating with the client are shown below in order from the lowest to the highest level.

LEVELS OF COMMUNICATION



In choosing levels of communication, the trainer should keep two principles in mind:

Minimum necessary. Start with the very lowest level you think is appropriate for the client and the task. Then, if he/she doesn't learn, you may switch to a higher level or use several in combination. For example, if the task is simple and you think the client is likely to learn it easily, powerful techniques like demonstration or physical prompting would probably be unnecessary and might even interfere with learning. On the other hand, if your client has not responded to verbal directions in the past, demonstration would be the most appropriate level. If the client still doesn't learn, you might switch to physical prompting or demonstration in combination with verbal instruction.

The proper time to interrupt behavior by giving assistance is when it appears that the client will make a mistake. If you wait until after the mistake is made, you give the client the chance to practice inappropriate behavior.

Fading. Offer less help as the training progresses. If the client accomplishes a task, or a step in the task, with lengthy verbal instruction, use a brief reminder on the next trial. A third trial might succeed with only silent observation. Eventually your client will be able to do the task with no help at all.

Example:

> Stylish Sue, who was able to put her coat on the table in front of her, could position it properly with only verbal instruction from the trainer. But even though the "putting the arms into the sleeves" step had been broken down into smaller steps for her and the trainer was continuing the verbal instruction, she was still having trouble. The trainer then decided to give physical prompting (guiding Sue's arms into the sleeves) as well as verbal instructions, and Sue was able to perform the behavior. During the next training session, the instructor observed silently and allowed Sue to continue until she had difficulty positioning the coat. At that point, instead of telling Sue what to do, the instructor merely said, "Try another way."

This example illustrates:

1. Minimum necessary
   Use the lowest powered technique possible.

2. Fading
   Give less help each time.

After you have determined how to communicate your expectations, you must decide how you will let the client know when he/she is doing the task correctly. **Reinforcement** is the best means of accomplishing this. By using a pat on the back, M&Ms, a smile, or praise, for example, you let the client know that he/she has done something right and you make him/her want to do it again.

Reinforcement increases the probability that behavior will occur. Punishment, on the other hand, can only eliminate old behavior. Punishment is sometimes useful for controlling a client, but it is not an effective way of helping a client learn new, appropriate behaviors.

Sometimes the best way to eliminate an old behavior is to reinforce a positive one to take its place. For example, rather than punishing a client for leaving a bed unmade, you might show him or her an easy way to accomplish the task and then offer praise in front of others. Even though you did not punish, the negative behavior—leaving the bed unmade—will probably soon disappear.

The principles of minimum necessary and fading apply to reinforcement as well as to levels of communication. You should not reward a client with M&Ms and kind words for a job well done when kind words alone would motivate him/her to do the task again. And while much reinforcement may be necessary at the beginning of training, you should use less and less as training progresses. Fading—both in levels of communication and in reinforcement—keeps the client from becoming too dependent on you and increases the chances that he/she will continue the new behavior after training is complete.

To be most effective, reinforcement should also:

1. **Be close to the event.**

   Reinforcement should follow the event or behavior it is intended to reinforce as closely as possible.

2. **Be natural.**

   The more natural the reinforcement, the easier it is for the client to make a transition from the training environment to the situation where the behavior will normally be performed. Clients working for a living in the "real world" are more likely to get a pat on the back, or even silence, for their efforts than M&Ms.

3. **Be something important to the client.**

   Always choose a reinforcer that is important to the client. If you are ever in doubt as to what this might be, ask the client! Don't assume that what is reinforcing to you or to others is reinforcing to your client. Reinforcers will vary from client to client and may even vary from time to time with the same client.

4. **Not be overdone.**

   If a client is constantly reinforced for any and every effort, he/she will soon realize that the trainer's expectations for performance are not very high. If *you* settle for a performance that is poor or just fair, why should *the client* try to do any better? Too much reinforcement may make a client unwilling to work for it. So if you find something that works, don't use it over and over again. Try never to interrupt appropriate behavior to reinforce it. Wait until the behavior is completed.

Of course, if you remember to involve the client in setting the goals and objectives of the program plan, the task should be reinforcing in and of itself. If it is something the client wants to learn, success should act as its own reinforcement.

Consider what levels of communication Louis will need to learn the task you have picked for him and which reinforcers are most likely to be effective. Keep the principle of minimum necessary in mind while writing your description on page 90 and include your plans for fading.

SUMMARY

The how part of a strategy, as you can see, is long and complicated. It is helpful, therefore, to have a brief description of the whole strategy, including who, when, and how. This summary lets you keep the whole strategy in mind instead of getting lost in the details. The strategies in the example on page 74 are really summaries of plans described in much greater detail.

Review the strategy that you have recorded on pages 89-90. Then write a summary of the strategy in three or four sentences.

CRITERION

Your strategy—telling who will do the training and when and how it will be done—is now basically complete.

You now have a much more specific idea of what you expect your client to accomplish than you had when writing objectives. So, as part of strategy development, you may need to expand or revise the criterion statement you made in your objective.

Criterion is the point at which you can assume that learning has taken place. A client has learned something when he/she repeats the behavior, without prompting, under the conditions where it is usually expected to occur. Thus, if you are teaching a client to make the bed, you may decide that he/she has mastered that task when he/she has made the bed three mornings in a row, without prompting, right after getting up.

You set criterion on the basis of what is normal for the task and the conditions under which the learned behavior is to be used. For many self-help tasks, social behavior, and work tasks, you might assume that a client has mastered the behavior if he/she performs it 90% of the time, or perhaps three out of every five times. But if a client's safety is involved—that is, if failure to do the task will result in injury—you can reasonably set criterion at no less than 100%.

Considering the information you have recorded as part of your strategy, particularly the steps in the task, set criterion for determining when Louis has mastered his task. Record the criterion on page 90.

Compare this criterion to the criterion in your objective for Louis.

	yes	no
Is the criterion you have now written more detailed than the criterion in the objective?	☐	☐
Is it more precise?	☐	☐
Will it give you more help in knowing when Louis has learned his task?	☐	☐

If you have answered "yes," formulating the strategy has helped clarify the objective. If your criterion has remained unchanged, the desired criterion was apparent at the time you wrote your objective.

EXERCISE: SIMULATED TRAINING

Having completed your strategy, use it to teach Louis how to perform the task. Keeping in mind his behavior and handicaps, role-play teaching the task, with group members assuming the roles of Louis and the trainer. Give everyone a chance to try being the trainer, but don't spend more than 10 or 15 minutes on these training trials.

STRATEGY REVISION

What happens when a strategy has been developed and training sessions have been conducted, but the client still is not learning the task? Concentrate on adjusting the strategy, not blaming the client or the trainer. Every part of your strategy may not work the first time. Be willing to revise and be flexible.

When it becomes apparent that learning is not taking place:

1. give a higher level of communication and/or different reinforcement. If more is needed,
2. revise the technique. If more is needed,
3. revise the steps of the task. If more is needed,
4. revise the method. If these revisions fail to produce learning,
5. revise the when and/or who portions of the strategy.

EXERCISE: STRATEGY REVISION

Your training trials may have given you ideas about ways to improve your strategy. Following the order for strategy revision given above, revise the parts of the strategy that did not work as well as you expected in the training trials. If there are a number of revisions, use the blank form on page 91.

IPP

REVIEW: STRATEGIES

In this session you selected an objective for Louis to work on. Then, to develop a strategy, you decided

WHO will do the training,

WHEN or how often, and

HOW it is to be done.

To determine the how part of the strategy, you selected which *method* the client will use to perform the task and determined the *steps in the task*. Then you completed your strategy by choosing a *technique* for presenting the material and planning the *trainer assistance*.

A *summary* of the who, when, and how parts of the strategy helped you get a good sense of the strategy as a whole.

Your strategy helped you review and clarify the criterion you had set as part of your objective.

Put your completed strategy and the revision back in your workbook now. They will be examples of a strategy when you need an example for review.

DISCUSSION: TEAM PROCESS

Now set your workbooks aside for 5-10 minutes and consider the group processes that have occurred during this session. How did your responsibilities as individual team members overlap? How did the group arrive at a consensus? Are you functioning as a core interdisciplinary team?

INDIVIDUAL PRACTICE: A STRATEGY FOR ACTIVE ANDY

Before adjourning, turn back to the objectives selected for Active Andy during the critiquing discussion at the beginning of this session. As a group, choose the objective for which you will individually develop a strategy before you meet next time. Choose an objective specifying a behavior that can be broken down into steps. Record the goal and objective on the form on page 93. Then decide together who will do the training and when. Before the next session, complete individually the how portion of the strategy, using the form on page 93. Remove the form from your workbook as you work on the strategy. Follow the step-by-step instructions for strategy development in Session 4. Return the form to your workbook when it is completed.

INDIVIDUAL PROGRAM PLAN

CLIENT Louis

GOAL _____

OBJECTIVE _____

_____

Barriers	Solutions
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

STRATEGY

Who _____

When _____

How _____

A. Method of doing the task

_____

_____

_____

_____

B. Steps in the task

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

89

IPP

9. _____

10. _____

11. _____

12. _____

13. _____

14. _____

15. _____

16. _____

C. Technique of presenting the task

_____

_____

_____

D. Trainer assistance

_____

_____

_____

_____

Summary _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Criterion _____

_____

INDIVIDUAL PROGRAM PLAN

(Revision)

CLIENT Louis

GOAL _____

OBJECTIVE _____

_____

Barriers	Solutions
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

STRATEGY

Who _____

When _____

How _____

A. Method of doing the task

_____

_____

_____

_____

B. Steps in the task

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

91

IPP

9. _____

10. _____

11. _____

12. _____

13. _____

14. _____

15. _____

16. _____

C. Technique of presenting the task

_____

_____

_____

D. Trainer assistance

_____

_____

_____

_____

Summary _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Criterion _____

_____

INDIVIDUAL PROGRAM PLAN

CLIENT Active Andy

GOAL _____

OBJECTIVE _____

_____

Barriers	Solutions
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

STRATEGY

Who _____

When _____

How _____

A. Method of doing the task

_____

_____

_____

_____

B. Steps in the task

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

93

IPP

9. _____

10. _____

11. _____

12. _____

13. _____

14. _____

15. _____

16. _____

C. Technique of presenting the task

_____

_____

_____

D. Trainer assistance

_____

_____

_____

_____

Summary _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Criterion _____

_____

IPP

SESSION 5: EVALUATION

Here is what you will do:

As a group, critique the strategies you have prepared individually for Active Andy.

Read the workbook information on process and product evaluation and do the group exercises.

Determine your procedures for evaluating the objective and strategy you have written for Louis.

Pick a client to prepare an IPP for in Session 6.

At the end of this session you will know how to:

Design and carry out process and product evaluations.

Note: You will not need the video equipment for this session.

SESSION 5

CRITIQUE: A STRATEGY FOR ACTIVE ANDY

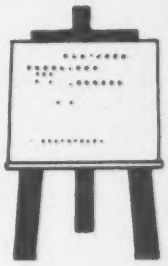
So far you have developed and critiqued a strengths/needs list, goals, and objectives for Active Andy. During this critiquing session, your team objective will be to select and revise one strategy from those you planned individually. Each of you will use the strategy you choose as a group in your next individual practice exercise.

Let one group member volunteer to read his or her strategy. If several people volunteer, let each one read the strategy summary. Then the group can decide which strategy sounds most appropriate.

Discuss, critique, and revise as necessary each part of the strategy you choose.

When you have agreed on the strategy, record below the summary of it and the steps in the task.

While time limits you in this session to dealing in depth with only one team member's strategy, other people may want feedback from the group on their strategies. Offer as much help as you can without making this team meeting last longer than 15 or 20 minutes. If more group response to individuals is needed, you may want to arrange for those interested to get together at another time.



INDIVIDUAL PROGRAM PLAN

CLIENT Active Andy

GOAL _____

OBJECTIVE _____

_____

STRATEGY (Summary) _____

_____

_____

_____

_____

_____

_____

_____

_____

Steps in the task

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

EVALUATION

Read aloud, rotating readers.

It could be frustrating to plan your goals, objectives, and strategies carefully if you didn't have a way of knowing whether your strategies were working and whether your goals and objectives were being met. After all the skill, time, and concern for your clients that you put into developing an IPP, you need and deserve some proof that you are providing a quality service to your clients.

There are different ways of getting feedback on how you are succeeding with your planning and training.

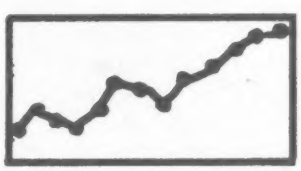
You can guess.

You can judge subjectively.

You can rely on the guesses and subjective judgments of other people.

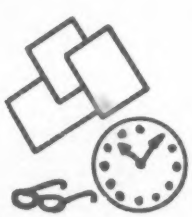
OR:

You can depend on empirical evidence. That is, you can measure, observe, and record client behavior before, during, and after training. These records prove to you beyond question how much adaptive behavior the client has gained in the training.



Collecting empirical evidence of client behavior change that results from training is what we mean by **evaluation**, the fourth part of an IPP.

Some people are turned off by the whole concept of evaluation, even by the work itself. It makes some staff members think of endless paperwork. Other people object to spending time preparing evaluations, time they feel they should be using in direct service to their clients. Still others are threatened by the thought that their supervisors will use their records to criticize their work.



If you have negative feelings about evaluation, discuss them as a group now, to get them in the open.

When did those feelings originate—in school, at work, or at home?

Have you had a negative experience doing evaluations in your agency or elsewhere in a similar situation? If so, what do you think is wrong with the way evaluations are conducted in that situation? In what ways could that system of doing evaluations be improved?

Can you set aside your feelings about evaluation in other situations, and come with an open mind to the present training?

Evaluation can help:

You (It provides you with the feedback you need and deserve, and gives you a record of your accomplishments, often with less time and paperwork than the reports you do now.)

Clients (It lets you pinpoint the weak points of your training procedures and helps you correct them. You thus become more effective, and your clients learn more readily.)

Agencies (Records are absolutely essential for acquiring funds, for receiving and maintaining accreditation, and for meeting any legal challenges. They are also required by law.)

Evaluation will measure two things for you:

1. Whether your strategies (your training procedures) are working.

   This is called **process** evaluation.

2. Whether your objectives (the outcome of training) are being met.

   This is called **product** evaluation.

While process and product evaluation measure two different kinds of things, the evaluator uses the same data to prepare both. A process evaluation is the result of observing and recording the client's behavior during each training session. A product evaluation is the summary of the data collected for the process evaluation.

THE TALE OF STYLISH SUE AND HER COAT

or

HOW THE TRAINER KNEW THAT SUE WAS "MAKING IT"

This story follows the steps of a program to train Stylish Sue to put on her coat correctly each morning before she goes outside to get to the recreation building.

The moral of the story is that the only way a trainer can *know* that he or she is using effective strategies and meeting the objectives is with process and product evaluation.

Sue and her interdisciplinary team met one afternoon to discuss ways in which they could help Sue "make it" in society. Sue said that she liked to dress up and wished she could do it all by herself. One team member pointed out that Sue already could get some of her clothes on, but had not yet mastered some of the details of dressing. The team agreed that Sue's spastic cerebral palsy would not interfere with her ability to dress neatly.

So Sue and the team wrote a goal:

> "Improve personal appearance."

Then they wrote several objectives, one of which was:

> "Within 3 weeks Stylish Sue will put on her coat correctly each morning before going outside for recreation."

The team decided that I. M. Able, the direct care person whom they selected to train Sue in this task, would define "correctly" when she prepared her strategy. They agreed that Sue would reach criterion when she completed all the steps in putting on a coat correctly on 3 successive mornings.

After the team meeting, Ms. Able wrote a strategy and made some plans for doing process and product evaluations.

In preparing her strategy, Ms. Able first thought about the best way for Sue to put on her coat. Since Sue has spastic cerebral palsy and lacks the motor skills to find a sleeve opening behind her back, Ms. Able decided to show Sue how to get her coat on by slipping her arms into the sleeves of the coat placed on a table in front of her, then pulling the coat over her head and onto her shoulders *(using the method illustrated on page 78).*

After Ms. Able had decided upon this method of putting on a coat, she broke the task down into small steps.

In thinking about which technique to use to present the task to Sue, Ms. Able considered the technique of forward chaining. But on the basis of her experience with Sue in other training efforts, Ms. Able guessed that Sue would become bored repeating the early steps of the task on each trial. So she chose instead the technique of total task presentation, letting Sue complete all the steps of the task on each trial.

Ms. Able also decided to offer the minimum assistance necessary to help Sue accomplish each of the steps, and to reduce her assistance as Sue became more independent.

In making further plans for training and evaluation, Ms. Able referred to the objective. The objective specified that Sue would put on her coat correctly within 3 weeks. So Ms. Able scheduled a 3-week training program.

The objective also specified that Sue would put on her coat correctly each morning before recreation, so Ms. Able scheduled the training sessions just before recreation period. She knew that training sessions are most effective if they occur at the time when you expect the client to do the task.

Then Ms. Able planned some evaluation procedures.

Since she didn't want to spend all her time recording and no time helping Sue, she drew a chart for keeping her daily records. She could record on the chart all the necessary information quickly, using symbols rather than words or phrases.

She listed on her chart each of the steps in putting on a coat as well as the dates of the training sessions. She planned to record how well Sue did on each of the steps each day and how much help she required. With this continuous record, or *process evaluation*, she could identify any trouble spots that might develop. This process evaluation would let her know whether her strategy was working.

Ms. Able first used her chart at the *pretest*, which she scheduled to find out how many of the steps in putting on a coat Sue could do. At the pretest, Ms. Able demonstrated the method of putting on a coat that she wanted Sue to learn. Then she asked Sue to try to put on her coat in the same way. She gave no assistance during this trial because she wanted to know how much of the task Sue could do without help.

The pretest provided Ms. Able with *baseline data*, or information about the client's behavior *before training began*. This baseline data, when compared with outcome data, would let her say in her product evaluation exactly how much behavior the client had mastered during training.

The numbers in Ms. Able's chart refer to the *highest* level of communication she used to get Sue to complete the step. Ms. Able indicated the level of communication with these numbers.

1—silent observation
2—verbal prompting
3—demonstration
4—physical prompting
0—the step was not completed by the client

A "2" on the chart means that Sue completed the step with verbal prompting from the trainer. A "3" means that the trainer had to demonstrate the step before Sue completed it. A "0" means that Sue did not complete the step, even with maximum assistance.

Ms. Able recorded the numbers as each step was completed.

A check in the pretest column means that Sue completed the step without assistance. Ms. Able used a different symbol for the pretest because she gave no assistance during it.

The chart shows the results of the pretest and four training sessions.

This chart is only an example of what a process evaluation *might* look like. When you design your record-keeping forms, you must adapt them to your own needs. For example, you might want to include information about what types of reinforcement you used, variations in training environment, length of time for each training trial, or other information that would help you judge the effectiveness of your efforts.

EVALUATION

CLIENT Stylish Sue TRAINING SCHEDULE Weekday Mornings 9 A.M.

TRAINER I. M. Able

STEPS IN PUTTING ON A COAT*	Pretest	Nov. 1	Nov. 2	Nov. 3	Nov. 4	Nov. 5	Nov. 8	Nov. 9	Nov. 10	Nov. 11	Nov. 12	Nov. 15	Nov. 16	Nov. 17	Nov. 18	Nov. 19
1. Place on table label up.	✓	1	1	1	1											
2. Turn collar toward you.	✓	1	1	2	1											
3. Open the coat.	0	3	3	2	2											
4. Hold arms out.	✓	2	1	2	1											
5. Aim at sleeves.	0	4	3	3	2											
6. Slide arms into sleeves.	0	4	4	4	4											
7. Throw arms over head.	0	4	3	4	2											
8. Pull arms down.	0	3	2	2	1											

*The steps are described more fully on page 80.

(Story to be continued)

EXERCISE: READING A CHART

Here are some questions to help you be sure you understand what information is presented on the chart. Perhaps one member of the group can read the questions while the others look closely at the chart.

1. According to the chart, what would be the first step in putting on a coat? _____

   _____

2. What steps was Sue able to accomplish in the pretest? _____

   _____

3. How many training sessions does Ms. Able estimate? _____

   _____

4. What step gave Sue the most trouble during the first week of training, and how do you know? _____

   _____

5. Do you note any pattern to the level of communication Ms. Able gave? _____

   _____

   _____

1. Place the coat on the table, label facing up.
2. Steps 1, 2, and 4.
3. 15 sessions, or 5 each week of the 3-week training period.
4. Step 6—Slide arms into the sleeves. Ms. Able had to physically prompt this step more than any other.
5. Ms. Able is fading assistance so that Sue won't come to depend on it.

Maybe you are wondering whether you couldn't just look to see whether Sue gets her coat on correctly and avoid all these charts. Well, yes, maybe you can, especially if she is quite successful from the start. But this careful process evaluation can tell you so much more than a casual observation. With it you can discover not only whether the strategy in general is working, but which specific steps in the task are stumbling blocks. For example, I. M. Able discovered after a few days that Sue was making good progress with all the steps but the sixth one, sliding her arms into the sleeves.

What could you assume if Sue is able to perform all but this step with no help or only verbal help, but consistently requires physical help for step #6?

_____

_____

_____

_____

_____

_____

You might assume things such as the following:

1. Communication is inadequate for this step.
2. The step is too complicated and must be broken down into smaller steps.
3. Sue is not physically able to master this step alone; thus, the steps in the task must be revised.

If you did not have the specific information that step #6 is a stumbling block, Sue might never master the task and you wouldn't be sure why. With the data collected in your process evaluation, you have pinpointed a problem and can work for a specific solution.

(If Sue didn't master her task and no one could tell why, Ms. Able would have been MiSerAble.)

(Story continued)

When Sue completed without help all the steps in putting on a coat 3 consecutive days, Ms. Able knew that she had reached criterion. So even though there were two more training sessions scheduled in the 3-week period, she considered training complete.

The process data Ms. Able recorded on the final day of training also served as her outcome data. This outcome data, compared with baseline data taken at the pretest, showed her what Sue has accomplished during training. This was good information to use in her *product evaluation*, which would let her determine whether the objective had been met.

EVALUATION

CLIENT Stylish Sue TRAINING SCHEDULE Weekday Mornings 9 A.M.

TRAINER I. M. Able

STEPS IN PUTTING ON A COAT*	Pretest	Nov. 1	Nov. 2	Nov. 3	Nov. 4	Nov. 5	Nov. 8	Nov. 9	Nov. 10	Nov. 11	Nov. 12	Nov. 15	Nov. 16	Nov. 17	Nov. 18	Nov. 19
1. Place on table label up.	✓	1	1	1	1	1	2	1	1	1	1	1	1	1		
2. Turn collar toward you.	✓	1	1	2	1	1	2	2	1	1	1	1	1	1		
3. Open the coat.	0	3	3	2	2	3	2	2	1	1	1	1	1	1		
4. Hold arms out.	✓	2	1	2	1	1	1	2	1	1	1	1	1	1		
5. Aim at sleeves.	0	4	3	3	2	3	2	2	2	1	2	1	1	1		
6. Slide arms into sleeves.	0	4	4	4	4	3	4	3	3	2	2	1	1	1		
7. Throw arms over head.	0	4	3	4	2	2	3	2	2	1	1	1	1	1		
8. Pull arms down.	0	3	2	2	1	1	2	1	1	1	1	1	1	1		

*The steps are described more fully on page 80.

IPP

Ms. Able needed to know for her product evaluation:

1. Does Sue put on her coat correctly?
2. Does she put on her coat correctly each morning?
3. Has she mastered this behavior within the 3-week training period?

Since the objective was behavioral, outcome-oriented, and time-linked, it was easy for Ms. Able to determine whether her client exhibited the desired behavior and at the time specified.

Pretest
(baseline data)

Posttest
(outcome data)

You see, this story has a happy ending! Sue did master the task of putting on her coat properly each morning. Ms. Able said, "I helped her not to need me and now she is able to dress herself attractively."

Comparing her baseline data and outcome data, Ms. Able had empirical evidence of her success as a trainer. She confidently reported her success to the interdisciplinary team, and they planned with pleasure and pride to work on a new objective.

THE END

THE TALE OF STYLISH SUE: FOLLOW-UP

After the training period is over, your process and product evaluations are still useful. As part of the written individual program plan and the client's permanent file, they are necessary for any follow-up studies you do to be sure that a client has acquired a behavior permanently.

For example, using the same forms she used for evaluating Sue during the 3-week training period, Ms. Able can check her periodically to make sure she continues to put on her coat correctly each morning. Maybe over the summer Sue will lose the skill to put on the coat or will forget when to do so. Then Ms. Able's records of Sue's behavior and her own teaching strategy will make it easy to plan refresher training.

An IPP, including an evaluation, is *written down* for your advantage.

PRODUCT EVALUATION: A DIFFERENT PERSPECTIVE

So far we have been illustrating process and product evaluation as they apply to training one client to meet one objective. But product evaluation can also show the broader outcome of your training activities over a longer period of time.

For example, product evaluation can be useful when you prepare periodic reports of progress on clients. For such reports you can compile your evaluations on a client's progress in reaching single objectives to show his or her progress in reaching goals. Periodic progress reports can thus be very specific, and you can back up the claims you make in them by empirical evidence.

Product evaluation can also provide information about groups of people over long periods of time. You might, for example, be training a large group of people to assemble electric circuits for a local electronics company. In this case, product evaluation, summarizing individual progress, will reveal such things as what percentage of the group learned the task and to what degree of accuracy. Product evaluation, referring to large groups, can provide a broad picture of what an agency has accomplished in a given period.

QUESTIONS AND DISCUSSION: EVALUATION

What kind of data should one collect for evaluations?

Your objective will help you focus on the behavior your client is learning, the expected outcome of training including criterion, and your target date. Thus, if the objective specifies that a client within 1 month will walk for 20 minutes without taking a rest on 3 consecutive days, you know that you must measure the duration of his/her walks, the training session intervals, and dates. It should be routine to include the name of the trainer. Your strategy will help you determine what additional data, such as amount and kind of feedback, are necessary.

What form should you use for taking data?

You may choose to record data in one of the following ways:

charts
graphs (bar graphs, line graphs)
attendance records
anecdotal records (narrative notes on daily activities)
established observation and behavior analysis schemes

Or it may be appropriate to use a combination of these forms.

You can also use standardized tests and interview scales for evaluation. But keep in mind that such numerical summaries of behavior are seldom helpful in predicting how a client will *act* in a given situation.

Your evaluation form will probably be attached to the IPP form your agency has adopted. The IPP form will indicate where evaluation data are available.

Whatever form you use for reporting data, you should base your reports on direct observations of behavior. (If your objectives are behavioral, you will have specified behaviors that are observable and measurable.) Try to observe the behavior in a natural situation. You want to know how a client is going to act in the future, without artificial stimulation or distraction.

How frequently should you take data for evaluation?

How often you observe and record a client's behavior during a training session—constantly, randomly, or at scheduled intervals—depends on the situation.

For example, if one person is taking data on several persons in a group, the observations must necessarily be either random or scheduled (unless the observer has several pairs of eyes and hands).

But when trainer and client are in a one-to-one situation (as in the case of Stylish Sue and her coat), the trainer can observe constantly. Sue's particular task of putting on her coat in several steps also requires constant observation. However, if your objective is that a client attend to a task in the workshop for a 1-hour period, you will observe him/her at intervals over the period to determine whether he/she is attending.

How can you keep records and train at the same time?

It does take a lot of skillful coordination and experience to manage two tasks at once. Sometimes it is impossible (as when you are physically involved in the training). In those cases you will need an assistant. Think about the possibility of having another client help you with data collecting!

You don't want recording to interfere with service, but remember that without empirical data of your evaluation, you don't know whether you are providing the service your client needs.

REVIEW: EVALUATION PROCEDURE

Let's review the evaluation procedure now. If any points of the review seem unfamiliar or confusing to you, take some time for group discussion to clear up any questions. If necessary refer to the pages in parentheses to refresh your memories.

1. There are two kinds of evaluation:

   process evaluation, for which you keep records during each training session to see if your *strategies* are working (pages 100, 102-103)

   product evaluation, which is a summary of process evaluation to reveal whether your *objectives* have been met (pages 100, 106-108)

2. Since evaluation measures what has been accomplished in training, it is important to have records of where training began, or some *baseline data* (page 102).

3. The person who actually does the training will also design the evaluation procedure and keep the records, but he or she will consult with the interdisciplinary team and report to them.

   When more than one person is involved in the training, each trainer must keep records. For example, if you are working on a behavior that applies to both the workshop and the recreation room, trainers in both those settings will keep records, in a format that they have agreed upon.

4. Evaluation, as a part of the written IPP, provides you with a permanent record of your methods and accomplishments. These records are necessary to you and to your clients as you plan future programs; they are also necessary to your agency, in its quest for funding, accreditation, and conformity with the law.

APPLICATION: EVALUATION FOR LOUIS

While you have not been involved in actually training Louis, you can plan how you would do your process and product evaluations using the objective and strategy you have agreed on as a group for him.

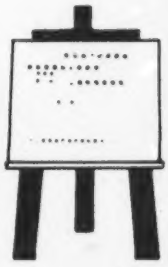
Even though in an actual training situation the trainer or trainers might plan the evaluation procedure independently, work as a team on this assignment in order to take advantage of feedback from all group members. The following questions will help you get started in planning your evaluation procedure.

What data will you need to collect? (Refer to your objective and strategy.)

What will be the best format for recording it?

Will the evaluator need to observe Louis constantly, randomly, or at scheduled intervals?

Will you need to observe Louis in more than one setting, and will more than one observer-trainer be involved? If so, what arrangements will you make to coordinate your data collection?



After agreeing on an evaluation procedure for Louis, record your plan on the next page. Then be sure to read the following page for more group assignments and your individual practice assignment.

INDIVIDUAL PROGRAM PLAN

EVALUATION

CLIENT Louis

GOAL _____

OBJECTIVE _____

STRATEGY (summary) _____

_____

_____

_____

_____

_____

_____

IPP

EVALUATION PROCEDURE

IPP

EXERCISE: SELECTING A CLIENT FOR SESSION 6

In Session 6 of this training, the final session, you will prepare a complete individual program plan for a client, including goals, objectives, strategies, and evaluation.

***If you are an intact interdisciplinary team,** that is, if you work together in an agency with clients, you may want to pick one of your own clients to write an IPP for. If so, decide now who that client will be, and whether team members need any special preparation—for example, observation or reading written reports—to write an IPP for him or her. Assign one member of the core team to prepare a strengths/needs list for your client. (Other members may contribute to the list.)*

***If you are not an intact interdisciplinary team**, that is, if you have met together only for the purpose of this training and if you do not have mutual clients, you may work in Session 6 with the videotape client, Cindy. Before Session 6 meets, read the background information on Cindy in Appendix C. Be sure to arrange for videotape equipment for Session 6.*

INDIVIDUAL PRACTICE: EVALUATION FOR ACTIVE ANDY

Determine your methods for evaluating the strategy and objective you have agreed on as a group for Active Andy. Record your plans (including any charts or other forms) below.

INDIVIDUAL PROGRAM PLAN

EVALUATION

CLIENT Active Andy

GOAL _____

OBJECTIVE _____

STRATEGY (summary) _____

_____

_____

_____

_____

_____

_____

_____

EVALUATION PROCEDURE

IPP

SESSION 6: APPLICATION: GET IT TOGETHER

Here is what you will do:

Critique the individual practice assignment on evaluation for Active Andy.

Develop a complete IPP either for a client from your agency, or for the client on videotape.

At the end of this session you will know how to:

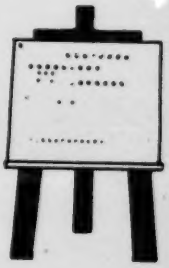
Write an individual program plan.

Note: You will need the video equipment for this session if you are going to write an IPP for the client on videotape.

SESSION 6

CRITIQUE: EVALUATION FOR ACTIVE ANDY

The objective of this group critique of individual work on evaluation procedures should be to decide as a group on a procedure that will provide all the information that you as individuals have determined necessary. An efficient way to pursue this objective would be for one group member to record his or her evaluation plan on the blackboard or easel. Other group members can contribute in turn their ideas about information to include in the evaluation report and about ways of recording the information easily and effectively. When you are satisfied with the consensus evaluation procedure, record it below.



EVALUATION

CLIENT Active Andy

APPLICATION: WRITING AN IPP

For the remainder of this session, you will work as an interdisciplinary team formulating a complete IPP either for the client in your agency that you selected in Session 5, or for the client on videotape. You will be writing goals, objectives, a strategy, and an evaluation procedure for this client. Should you need to review how to write any of these four basic parts of an IPP, the following "Brief Review of the Basic Principles" may be helpful. If you need a fuller discussion of these principles, refer to appropriate sections in the workbook.

As a group, critique everything you write, according to the criteria set in previous sessions.

If you are going to develop an IPP for a client in your agency, turn ahead in your workbook to page 120 and begin a strengths/needs list for the client.

If you are going to develop an IPP for Cindy, watch her on videotape now.

Set Tape 2 at counter number 000 and turn it forward to the number where the presentation for Louis ended in Session 3.

When you have finished watching the videotape, begin her IPP by completing the strengths/needs list on page 120.

"Cindy"

Presentation begins at approximate counter number 586

NOTES _____

THE IPP: BRIEF REVIEW OF BASIC PRINCIPLES

Strengths/Needs List: encourages a positive approach to the IPP by specifying client strengths as well as client needs.

Under *strengths*, include what the client can do, what the client likes to do, people who are willing to help.

Under *needs*, state in positive terms what you and the client would like to accomplish. Use the client's strengths to help meet the needs.

Goals: show the general direction of treatment. When writing goals you should:

use positive language

create competencies as well as eliminate deviancies

limit goals to two or three at a time for each client

take into account the sequence of development

include both short- and long-range goals

be realistic

make your goals understandable and important to the client

Objectives: tell in behavioral terms what the client will *do* when training is completed. Objectives are:

behavioral (they specify measurable and observable behavior)

outcome-oriented (they tell what the client's behavior will be at the end of training)

time-linked (they tell how long the client will take to learn a behavior and how often he/she will do it)

Objectives are also positive and realistic, and they emphasize competency.

Strategies: are your training procedures, telling *who* will do the training, and *when* and *how* it will be done. To determine *how* to accomplish an objective, you:

select a *method* of doing the task

determine the *steps in the task*

plan a *technique* to use to present the task

plan *trainer assistance*

Evaluation: provides empirical data about the success of your training program.

Process evaluation, during each training session, monitors whether your strategies are working.

Product evaluation, at the end of the training, tells whether an objective has been met.

STRENGTHS/NEEDS LIST

CLIENT _____

Strengths	Needs

IPP

GOALS AND OBJECTIVES

Write two or three goals for your client and two or three objectives for each goal. Rank your goals and objectives. That is, decide the order in which you will pursue them.

GOAL 1 _____

OBJECTIVES: 1. _____

_____

2. _____

_____

3. _____

_____

GOAL 2 _____

OBJECTIVES: 1. _____

_____

2. _____

_____

3. _____

_____

GOAL 3 _____

OBJECTIVES: 1. _____

_____

2. _____

_____

3. _____

_____

STRATEGY

Select one objective and write a strategy for it.

OBJECTIVE _____

_____

Barriers	Solutions
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

STRATEGY

Who _____

When _____

How _____

A. Method of doing the task

_____

_____

_____

_____

B. Steps in the task

1. _____
2. _____
3. _____
4. _____
5. _____

IPP

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

C. Technique of presenting the task

_____

_____

_____

D. Trainer assistance

_____

_____

_____

_____

Summary _____

_____

_____

_____

_____

_____

Criterion _____

_____

EVALUATION

Determine a procedure for evaluating the strategy you have just written and for determining whether the objective has been met. Decide on a form for recording data, what information to include on the form, and the frequency with which you will observe the client's behavior. Record your plans below.

EXERCISE: PLANNING FOR THE FUTURE

During this training you have learned how individual program planning can assure your clients of receiving the best possible help that you can give them, because you set goals and objectives according to their strengths and needs, develop strategies to meet those goals and objectives, and make sure with evaluation that your plan is succeeding.

The concept of program planning can also help assure *you* of being effective in your job. You can set goals and objectives for yourselves, think of strategies for meeting them, and plan ways of evaluating your progress.

A commitment to use and improve the skills you have gained in this training is the first step in insuring that you will succeed in individual program planning. You can express such a commitment by setting goals and objectives for yourselves. Begin thinking about possible goals and objectives by reviewing the objectives you set for yourselves as a team and as individuals in Session 1. As a group discuss for a few minutes how well you have met your objectives for training. If you have not yet met some of those objectives, remember that "training" does not end with the conclusion of this course. You will continue to learn and to refine your skills as you have the chance to use them in your work. Discuss now whether your training objectives are still realistic, whether you can continue to pursue them, and ways in which you might pursue them in the work setting.

The space below is provided for you to write some goals and objectives for yourselves for the future. You may want to include among them some of the objectives you set for yourselves in Session 1. Your goals and objectives should reflect how you want to implement the ideas you have learned in this training.

TEAM GOALS

_____

_____

_____

TEAM OBJECTIVES

_____

_____

_____

_____

_____

_____

_____

_____

As you know from going through this training, simply stating objectives does not insure that you will meet objectives. So plan some strategies for meeting your team objectives. For example, will you need to continue meeting as a team? If so, you may set some meeting times as part of one strategy. Or, you may want to meet informally for discussion and to give each other support. Planning a way of evaluating your strategies and your progress towards meeting objectives can also help. Record your strategies and evaluation procedure below.

TEAM STRATEGIES

_____

_____

_____

_____

_____

_____

EVALUATION PROCEDURE

As individuals you may have additional goals and objectives for yourselves. Think about future development as an individual on an interdisciplinary team. Group members can help each other get started with developing personal objectives by sharing their thoughts about ways in which they want to grow as team members. Individuals may want to add to their list of objectives later. Record your objectives below, along with strategies and evaluation procedure.

INDIVIDUAL OBJECTIVES

INDIVIDUAL STRATEGIES

EVALUATION PROCEDURE

AFTERWORD

You have now completed your training in individual program planning with developmentally disabled persons. This training has presented a model of an IPP with four basic parts: goals, objectives, strategies, and evaluation. As you become more familiar and increasingly skillful with the procedures for writing an IPP, you may want to adapt this basic model to better suit your own needs. Some principles of the IPP remain constant: they are written by an interdisciplinary team for every client accepted for services, they include long-term and short-term goals and objectives, are reviewed at least annually, and involve the client or his/her advocate to the fullest possible extent. But the forms we have used in this training package, and those that appear in the appendix, are merely examples of how an IPP *might* be written, and are not intended to interfere with your creativity and imagination in developing your own forms.

Program plans are individualized because that is the only way to assure each developmentally disabled person of a program of education and training designed for his/her own particular needs. This kind of planning for clients demands your greatest sensitivity and motivation. As you work with IPPs there may be times when you become frustrated and would like to slip into the habits of generalizing about your clients or even ignoring the ones who are most difficult. But if you write your IPPs conscientiously and approach your training as carefully as you plan, you will find client achievement where you expected none. You will be giving your clients the best chance they have had yet to "make it" in society.

APPENDIX A

LITIGATION, LEGISLATION, AND ACCREDITATION

LITIGATION

Pennsylvania Association for Retarded Children v. *Commonwealth of Pennsylvania* (1972) established the right of every mentally retarded child to a "free program of education and training."

In addition, the court decided that "all mentally retarded persons are capable of benefitting from a program of education and training; that the greatest number of retarded persons, given such education and training, are capable of achieving self-sufficiency, and the remaining few, with such education and training, are capable of achieving some degree of self-care; that the earlier such education and training begins, the more thoroughly and more efficiently a mentally retarded person will benefit from it and, whether begun early or not, that a mentally retarded person can benefit at any point in his life and development from a program of education."

Once the right to a "free program of education and training" was established, the rights of developmentally disabled persons to *specific* services (that is, with an individualized program plan designed to maximize their abilities) in the least restrictive environment became a major concern. Many court decisions since the landmark decision of 1972, in fact, have upheld these rights.

A 1974 publication of the Legal Rights Work Group of the President's Committee on Mental Retardation lists 20 completed or pending cases in this area. Of the decisions handed down, *10 were in favor of the plaintiff* and only two against. Eight decisions were still pending when the information went to press in October of 1974 and one decision was under appeal.

One of the most notable cases is *Wyatt* v. *Stickney* (Alabama). A 1974 decision in favor of the plaintiff establishes the right to: (1) an individualized treatment program; (2) a humane physical and psychological environment; (3) an adequate and qualified staff; (4) programs provided in the least restrictive manner possible.

Davis v. *Watkins* (Ohio, 1974), which challenged the commitment and treatment of handicapped persons at Ohio's Maximum Security and Mental Hospital, incorporates many of the *Wyatt* Standards.

Donaldson v. *O'Connor* (Florida, 1974) establishes the constitutional right to treatment under the 14th Amendment and requires the award of damages for failure to provide such treatment while continuing to confine.

Welsch v. *Likins* (Minnesota, 1974) establishes the right to care and treatment in the least restrictive environment and further finds that confinement without treatment is probably "cruel and unusual punishment" under the Eighth Amendment to the Constitution.

For more information, see "Legal Rights" in the reference section.

LEGISLATION

1975 AMENDMENTS TO THE DEVELOPMENTAL DISABILITIES SERVICES AND FACILITIES CONSTRUCTION ACT

These Amendments, known as Public Law 94-103, establish that persons with developmental disabilities have the right to appropriate treatment, services, and habilitation for such disabilities. Additionally, these services "should be designed to maximize the developmental potential of the persons and should be provided in the setting that is least restrictive of the person's personal liberty."

Public funds (both federal and state) are to be withheld from agencies not meeting the general stipulations above and a number of specific program requirements, including the "habilitation plan."

The portion of the Amendments relating to this "habilitation plan" reads as follows:
"(b) A habilitation plan for a person with developmental disabilities shall meet the following requirements:

"(1) The plan shall be in writing.

"(2) The plan shall be developed jointly by (A) a representative or representatives of the program primarily responsible for delivering or coordinating the delivery of services to the person for whom the plan is established, (B) such person, and (C) where appropriate, such person's parents or guardian or other representative.

"(3) Such plan shall contain a statement of the long-term habilitation goals for the person and the intermediate habilitation objectives relating to the attainment of such goals. Such objectives shall be stated specifically and in sequence and shall be expressed in behavioral or other terms that provide measurable indices of progress. The plan shall (A) describe how the objective will be achieved and the barriers that might interfere with the achievement of them, (B) state an objective criteria and an evaluation procedure and schedule for determining whether such objectives and goals are being achieved, and (C) provide for a program coordinator who will be responsible for the implementation of the plan.

"(4) The plan shall contain a statement (in readily understandable form) of specific habilitation services to be provided, shall identify each agency which will deliver such services, shall describe the personnel (and their qualifications) necessary for the provision of such services, and shall specify the date of the initiation of each service to be provided and the anticipated duration of each such service.

"(5) The plan shall specify the role and objective of all parties to the implementation of the plan.

"(c) Each habilitation plan shall be reviewed at least annually by the agency primarily responsible for the delivery of services to the person for whom the plan was established or responsible for the coordination of the delivery of services to such person. In the course of the review, such person and the person's parents or guardian or other representative shall be given an opportunity to review such plan and to participate in its revision."

IPP

REHABILITATION ACT OF 1973

The Rehabilitation Act of 1973 (Public Law 93-112) requires both HEW (Department of Health, Education, and Welfare) and state vocational rehabilitation agencies to provide services on a priority basis to "those with the most severe handicaps, so that they may prepare for and engage in gainful employment."

This is to be done, the law states, through an Individualized Written Rehabilitation Plan (IWRP), which has the following characteristics:

1. It is initiated as soon as the counselor determines the client's eligibility or determines that the client will require extended evaluation.
2. It is maintained separately from the case record.
3. It is developed jointly by the counselor and the client and may be revised or amended with their agreement.
4. It documents financial considerations, client and counselor responsibilities, and contingencies that might affect the program.
5. It must include a vocational goal with intermediate objectives (or specified services) toward reaching that goal.
6. It must include an evaluation procedure.
7. It may be reviewed as often as necessary, but must be reviewed at least once a year as long as the case is open.
8. It must include information on case closure and plans for post-employment services.

Once the IWRP has been developed, it is signed by the counselor and a copy is given to the client.

REHABILITATION ACT EXTENSION

The Rehabilitation Act Extension of 1976 extends the authorization of appropriations for all programs under the Rehabilitation Act of 1973 for 1 year through September 30, 1977, with provision for automatic extension through September 30, 1978.

1975 EDUCATION OF ALL HANDICAPPED CHILDREN ACT

The approval of the 1975 Education of All Handicapped Children Act (Public Law 94-142) has the potential to create the most dramatic and comprehensive changes witnessed heretofore in the delivery of special education services. The Act mandates that all handicapped children residing in a state be identified, located, and evaluated and that a method be implemented to determine which children are or are not receiving needed special education and related services.

The Act also calls for the maintenance of records of each child's individualized educational program by every legally authorized educational agency in the state. The instructional plans shall include appropriate objective criteria and evaluation procedures and must be reviewed and revised at least annually. Opportunity for input in the development of these educational blueprints is afforded all principles in the educational environment. Included should be representatives of the administrative, instructional and diagnostic staff, as well as the child and his/her parents.

STATE PLANS

The 1975 Amendments to the Developmental Disabilities Services and Facilities Construction Act, the Rehabilitation Act of 1973, and the 1975 Education of All Handicapped Children Act are all federal/state legislation. This means that each state is responsible for developing a plan which outlines how that state will interpret and implement these federal laws and their accompanying regulations.

For more information on your state's plan, contact the State Developmental Disabilities Services Administration (concerning the 1975 Amendments to the Developmental Disabilities and Facilities Construction Act), the State Director of Rehabilitation (concerning the Rehabilitation Act of 1973), and/or the Director of Special Education, State Department of Education (concerning the 1975 Education of All Handicapped Children Act).

ACCREDITATION

ICF-MR (Intermediate Care Services in Facilities for the Mentally Retarded), CARF (Commission on Accreditation of Rehabilitation Facilities), and JCAH (Joint Commission on Accreditation of Hospitals) all require basically the same individual program plan discussed throughout this training. Goals, objectives, strategies and evaluation remain the four essential elements, and each accrediting body specifies that the plan must be written. In addition, all require an interdisciplinary team approach and the client's involvement in program planning. However, even though they agree on these general concepts, each accrediting body has it own language and specific requirements.

For state accreditation requirements, contact the appropriate state agency. In Texas, for example, contact:

Intermediate Care Services in Facilities for the Mentally Retarded
State Department of Public Welfare
John H. Reagan Building
Austin, Texas 78701

For more detailed information from national acceditation bodies, contact:

Commission on Accreditation of Rehabilitation Facilities
4001 West Devon Avenue
Chicago, Illinois 60646

Joint Commission on Accreditation of Hospitals
875 North Michigan Avenue
Chicago, Illinois 60611

APPENDIX B

BACKGROUND INFORMATION ON VIDEOTAPED CLIENT: LOUIS

PROGRAM PLANNING AND DISPOSITION UNIT
SOCIAL AND DEVELOPMENTAL HISTORY

Name of Client: Louis
Date of Interview: 04/15/76
Date of Birth: 02/30/63
Age: 13 years, 2 months
Interview Time: 1 hour

Case Number: 00000000
Place of Interview:
5000 Campus Drive
Informant: Mrs. Mary _____
Mother of Client

I. Referral Source

Louis has been referred to us for programming and behavioral control by the public schools.

II. Physical Description of Client

Louis is an ambulatory Anglo male who is about 4 feet 6 inches tall, and weighs 70 lbs. He has a small scar on his forehead, blue eyes, and dark brown hair. Louis has freckles across his nose and a small birthmark on his right leg.

III. The Family

Family Members: The family constellation consists of the father, Henry, age 40; the mother, Mary, age 38; a sister, JoAnn, age 16; a second sister, Helen, age 14; Louis, age 13; and Peggy, age 2½ months. There are no other adults or children living in the family.

Louis stays with his parents most of the time but is frequently left with a babysitter. Louis's older sisters are usually involved with school and school-related social activities. Mrs. _____ usually keeps Louis's younger sister. The whole family is apparently adjusting to Louis's disability, gives him a great deal of support, but regards him as a large pet.

Housing and Environment: Louis's family lives in the southeast part of town. They are buying their home and have lived there for 15 years. The three bedroom, wood frame house has a living/dining room combination, kitchen, bath, and carport. Louis has a bedroom which he shares with his youngest sister. The two older sisters share a second bedroom.

Socio-Economic: Louis's father works for American Founders Insurance. He has been with the company for 5 years. He has completed his high school education and 2 years of college.

Louis's mother has completed high school and some college. She frequently works out of the home on a volunteer basis.

Transportation: There are three cars in Louis's family; a 1975 Plymouth, a 1965 Dodge and a 1976 Ford. There are no problems with transportation as both parents drive and the oldest sister drives.

Family Dynamics: Louis's parents have been married for 17 years. This is the first marriage for the father, the second marriage for the mother. There are no children by Louis's mother's first marriage. The family and social life seem to revolve around each individual member of the family unit. The older girls are usually involved in school activities and are beginning to break away from the family somewhat. Louis's mother and father have their own individual social lives. The family unit, however, does enjoy going on picnics and outings to the lake as a unit.

Louis's mother is the dominant force in the family. She handles all paying of bills and finances. She explains that many of the decisions in the family are left to her and that she usually handles all discipline.

Communication patterns in the family seem to be somewhat strained. Louis's mother will generally make decisions and deal with any problem arising. The family tends either to avoid dealing with problems or to allow Mrs. ___ to handle any difficulty arising.

The family is not very open in demonstrating affection; however, they will verbalize some affection for each other. This verbalization of affections seems to revolve more around Mrs. _____ and the children than among the entire family unit. Mr. _____ generally is somewhat outside the family in terms of discipline, decision making, and expression of affection.

IV. Medical and Physical

Pre-Natal History: Mrs. _____'s pregnancy was full term; however, Louis was a breech birth. Labor had to be induced by Pitocin injection. Louis was born with one collapsed lung and was under oxygen for 6 days. He weighed 4 lbs., 10 ounces at birth. Mrs. _____ was 25 at the time of Louis's birth.

Post-Natal History: At birth and during the first weeks of Louis's life there were no indications of problems after the collapsed lung. Louis slept well but ate little. At 3 months, however, there seemed to be no appreciable weight gain. Louis was then switched to a formula, and did gain some weight but did not progress normally. By the fifth month there was a decided decline in Louis and some concern that he would be developmentally delayed. At about 7 months of age, Louis began to experience noticeable seizure activity peaking out at about 10 months with seizures lasting up to 4 hours. He was placed on Dilantin for seizure control but developed an allergic reaction to the Dilantin. He was then placed on phenobarbital for seizure control.

Former Medical: Louis has had chicken pox, measles, mumps, and all of his childhood immunizations. He is allergic to penicillin, sulfa drugs, and green vegetables. Louis's seizures are controlled by phenobarbital. He is a restless sleeper in the evenings and many times will sleepwalk at night.

Current Medical: Louis continues on phenobarbital for seizure control. He is under the care of Dr. John Smythe. Louis is scheduled to complete dental surgery within the next few weeks.

V. Developmental Background

Sensorimotor: Louis held his head up and sat unassisted at about 1 year of age. He never really crawled. He more or less wallowed around to move on the floor. Louis could not walk or talk until he was about 3½ years old at which time he received a severe electrical shock from a household electrical outlet. At that time he immediately began walking and saying individual words. After the incident Louis did regress to some degree, but has since learned to walk and express himself with single words, gestures and grunting.

Louis can finger feed himself and will occasionally eat with a spoon if he is very hungry. He generally will try to make his mother or some other person feed him and take care of his needs. Louis will attend to his toileting needs in his school setting but refuses to carry through on toileting needs at home. He will sit alone at home on the toilet when placed. However, Mrs. _____ generally will not carry him to the toilet.

Louis will help some with putting his arms into his clothing and pulling shirts down. However, he refuses to do more than this and manipulates his mother into dressing him. Louis is cooperative with other grooming needs such as hair brushing and teeth brushing. He enjoys his bath and will aid with washing.

Communicative: Louis will usually say single words such as "night-night," "Da-da," "Mama" and other such individual simple words. Louis generally pairs gestures, grunting noises, and single words in order to communicate his needs. He will scream and yell when angry, will often spit at or bite someone when antagonized, and has threatened to hit. When Louis is happy he will laugh and generally make pleasant sounding noises. He will oftentimes stroke an individual's arm or leg in order to indicate affection.

Self-Help Skills: Louis is beginning his toilet training, his grooming needs, and some of his eating skills.

Affective: According to the mother, Louis will often hit someone at home in order to gain attention. This behavior is controlled at home by the family members hitting Louis back. In the school setting Louis only threatens to hit without actually carrying through. Louis will spit at and scream at someone he is extremely angry with. Louis expresses other affection by stroking someone's arm or leg. He will laugh and make pleasant noises when happy. Mrs. _____ describes Louis as being a very nervous child who is always into something.

Social: Louis can eat at the table with his family although many times he will use ill table manners in order to gain attention. He does have some problems with chewing due to his orthodontic difficulties. Louis is generally disciplined verbally. Occasionally Mrs. _____ will paddle Louis with a belt. His general reaction to discipline is somewhat passive. Louis is a solitary person and generally spends a lot of time watching TV or deliberately aggravating another family member.

Many times Louis will not sit in a chair. At such times the family will tie Louis in the chair to make him be still. Louis interacts with his peers superficially; that is to say, he either aggravates, plays in the vicinity of, or ignores peers.

Cognitive: The mother explains that Louis is usually very aware of his surroundings particularly as to the moods of people. He knows his name, can print his name, and does enjoy TV, particularly talk shows. Mrs. _____ also says that Louis has a good memory for where he has left his toys and playthings. He can also remember where his toys and playthings are supposed to be.

VI. Educational and Other Services

He has been involved with the Independent School's special education program.

VII. Summary and Services Requested

Louis is an ambulatory 13-year-old male. He lives at home with his mother and father and three sisters. He has no specific MR syndrome although he is felt to be developmentally delayed. Louis has few self-help skills.

The family is requesting that Louis be enrolled in the Learning Center program. They request no other services at his time.

It is recommended that Louis be placed at the Learning Center program with special emphasis on development of his self-help skills and behavior control. Louis is in need of a better structured and healthier home environment. The family would seem to profit from involvement in a parenting group aimed at behavioral management of special children in the home.

N. C.

N. C., Caseworker
Evaluation Unit

NC:wpc/ja

CURRENT PSYCHOLOGICAL REPORT

Client Name: Louis
Date: 4/29/76
Date of Testing: 4/29/76
Sex: Male

Case Number: 00000000
Birthdate: 2/30/63
Age: 13 years, 2 months
Examiner: Psyche Rorschack, M.S.
Staff Psychologist

REASON FOR REFERRAL: Louis was referred to determine current level of functioning.

PREVIOUS TEST RESULTS: Apparently, no previous psychological evaluation has been administered.

TESTS ADMINISTERED: Cattell Infant Intelligence Scale, Vineland Social Maturity Scale—Marcus Welby, informant.

BEHAVIORAL OBSERVATIONS: Louis came to the testing session unwillingly and ambulated primarily on his knees. He cried throughout the session and repeatedly attempted to leave. He threw toys at the examiner, kicked, and pulled at the examiner's hair. He appeared to have good receptive language abilities; however, he appeared to actively resist following any verbal requests. His gross motor skills of the upper extremities and his fine motor skills appeared well developed. He was observed to have a neat pincer grasp, and was observed to hold a pencil appropriately but did not copy graphic shapes, although he appeared to have the ability to do so. He was observed to persistently reach and grasp objects but did not manipulate them purposefully. He was observed to visually track and fixate on objects and responded to auditory stimuli by turning his head. No verbalizations were observed. He did not attend to tasks and appeared easily distractible.

TEST RESULTS: On the Cattell Infant Intelligence Scale a basal score was established at the 12 month level with additional scattered credit through the 13th month. This performance yields a mental age of 12.2 months and a subsequent IQ of 8. It is felt that his uncooperative interfering behaviors severely affected the measured scores. His greatest area of strength appeared to be receptive language abilities although he does not willingly demonstrate this. On the Vineland Social Maturity Scale (Marcus Welby, informant), an age equivalence of 1.82 years was established with a resulting social quotient of 14. Mr. Welby reports that Louis can finger feed and drink without assistance. His lack of using utensils appears to be lack of training rather than inability. Mr. Welby reported that Louis is independent in his toileting skills. Mr. Welby reported also that Louis frequently takes off his clothes and upon verbal prompting he will re-dress himself. These test scores indicate Louis is currently in the profound range of mental retardation.

IPP

ADAPTIVE BEHAVIOR LEVEL:

Current: IV Potential: III

SUMMARY: Louis, a 13-year 2-month-old male, is currently functioning in the profound range of mental retardation. It is felt that with appropriate training and stimulation, Louis's level of functioning can be developed above that of the present. It appeared that his family and those around him did not expect or require him to behave and develop in an appropriate manner. It is felt his inappropriate behaviors will severely affect his learning and developmental progress unless they are controlled.

RECOMMENDATIONS:

1. Enrollment in a structured day programming environment such as the Learning Center.
2. Counseling and information for his mother regarding behavioral techniques to use with Louis.
3. Programming and stimulation in areas of language development and self-help skills.
4. Behavioral program to increase his appropriate behaviors, especially complying with requests and attending to tasks.
5. Physical therapy assessment to determine needed therapeutic intervention to improve and increase walking in an upright position.
6. Maximum opportunities for him to socialize with peers and adults.

SPEECH AND LANGUAGE EVALUATION

NAME: Louis
DATE: 4/10/76
DOT: 4/10/76
SEX: Male

Case No: 00000000
BD: 2/30/63
CA: 13 Years, 2 Mos.
EXAMINER: Audi Tory

REASON FOR REFERRAL: To determine level of speech and language functioning.

PREVIOUS TEST RESULTS: None available at this time.

TESTS ADMINISTERED: Communicative Evaluation Chart; informal observation.

BEHAVIORAL OBSERVATIONS: Louis's mother reported that Louis has never received speech and language therapy, and he has not shown significant changes in his speech and language in the last 6-12 months. She also stated that Louis has had no history of otitis media, and she does not suspect a hearing loss at this time.

During the evaluation, Louis sat alone in a large chair, head balance was somewhat difficult for him, and his behavior fluctuated between periods of animated movement with vocalization to periods in which he was very taciturn with eyes almost closed and no vocalization. This behavior was consistent, and was observed by all the clinicians including the physician.

TEST RESULTS: The Communicative Evaluation Chart was completed using information obtained from Louis's mother and from observation of Louis. At this time, Louis appeared to be functioning below the 3 month level in most speech and language abilities, with scatter into the 12 month level. He did not react to sudden noises nor heed spoken voices; he did not localize sound sources, and his responses to noisemakers were inconsistent. Louis did not appear to understand and respond to his name, nor follow simple directions.

Louis's expressive language skills consisted of vowels vocalized voluntarily, mainly in the form of an "ah" sound. No consonant phonemes were heard, and he did not babble. His vocalization did not appear to be made in order to communicate his wants and needs. Voice quality was somewhat hoarse at times. He used primitive gestures to indicate what he wanted when the item was in sight.

The oral peripheral examination revealed a marked distoclusion with micrognathia of the mandible. Tongue movements were poor upon request; the hard palate was somewhat high and narrow. The soft palate appeared to move adequately upon phonation, but velopharyngeal closure could not be determined. His mouth was open a great deal of the time, and he appeared to breathe through his mouth. Drooling was present throughout the evaluation.

SUMMARY AND RECOMMENDATIONS: Louis, 13 years, 2 months, appeared to be functioning at a significantly delayed level in most speech and language abilities at this time. Hearing sensitivity appeared to be questionable, due to his inconsistent responses to noisemakers and environmental sounds. Louis's expressive language consisted of vowel vocalizations and primitive gestures; the vocalization did not appear to be made in order to communicate his wants and needs. The oral peripheral examination revealed that Louis's oral mechanism did not appear to be adequate enough to support good speech and language development.

It was recommended that Louis be considered for enrollment at the Learning Center, with emphasis in his language program on responding more consistently to auditory stimuli (noisemakers, voice, etc.), following simple directions, encouraging more babbling. It was also recommended that he receive an audiological evaluation.

Audi Tory

Audi Tory, M.A.
Communication Specialist

APPENDIX C

BACKGROUND INFORMATION ON VIDEOTAPED CLIENT: CINDY

SOCIAL AND DEVELOPMENTAL HISTORY

Name: Cindy
Date of Interview: 7/21/76
Place of Interview: Administrative Office
Informants: Parents of Client

Case Number: 000000
Date of Birth: 2/30/61
Age: 15 years and 5 months
Interview Time: 1 hour

I. Referral Source

Cindy has been referred by her parents.

II. Physical Description of Client

Cindy is a non-ambulatory female with cerebral palsy. She has brown hair and brown eyes. Cindy weighs about 100 pounds.

III. The Family

Family Members: The family consists of Cindy and her parents. She has three brothers and an older sister all of wnom are married and live outside of the home.

Housing: This family is buying their three bedroom home in which they have lived for the past 12 years.

Socio-Economic: The father has completed his high school education and 1 year of college. He works for the Quik Print Company; he has been employed there for the past 6 years.

The mother does not work outside the home at this time. She has completed her 10th grade education and is presently enrolled in the Adult Basic Education program working toward her G.E.D.

Transportation: This family has no problem with transportation as they own several cars.

Family Dynamics: This family is a very cohesive and mutually supporting unit. They exhibit much warmth and concern toward each other. The mother assumes the bulk of the responsibility for Cindy's care; the father, however, apparently enjoys his daughter also and spends as much time as possible with her. The family works together in seeking resources for Cindy. They seem to have open, warm communication family patterns.

This family is devoted to the care of Cindy. They are ready to carry through on any programming needs for her and are concerned that she receive the appropriate training.

Current Medical: Cindy has some chronic problems with circulation in her legs. Due to these problems she is able to sit for only short periods. Cindy also has chronic problems with constipation. Cindy receives medication to reduce muscle spasms and to control

her seizure activity. The mother was unable to remember the specific medication for seizure control.

Formal Medical: Cindy was diagnosed as cerebral palsied at age 1 year. She has had numerous operations on her feet and legs to relieve contractures. In 1970 Cindy underwent surgery to correct a dislocated hip.

Pre-Natal History: This mother experienced a great deal of difficulty during her pregnancy. She was extremely ill during the entire pregnancy with various viral and bacterial infections. She had to remain in bed from her seventh month until delivery.

Post-Natal History: Cindy was 1 month premature. She weighed 4 pounds at birth. Difficulties with breathing were experienced during her 60-day hospital stay. These difficulties have decreased with age.

V. Developmental Background

Sensorimotor: Cindy has limited motor ability. She can hold her head up unassisted for only several minutes. She can sit in her wheelchair for limited times only due to her poor circulation. Cindy has some visual impairment but the extent of this impairment has not yet been ascertained.

Communicative: The parents suspect no problem with Cindy's hearing. They relate she can speak in sentences and can be understood by a stranger. She laughs and smiles appropriately.

Self-Help Skills: Cindy is on a soft diet. She is beginning to attempt to use a spoon. She is able to complete some finger feeding.

Cindy indicates when she needs to go to the toilet. She assists passively in her dressing and undressing as well as in her bathing. She has no other self-help skills.

Social: The parents relate that Cindy is distractible and hyperactive. They state she is, however, usually a happy and busy child.

Affective: Cindy has some irritability around the time of her menstrual period. She expresses affection to her family by kissing and hugging them. She pouts when she is angry.

Cognitive: Cindy reacts favorably to environmental stimuli.

VI. Education and Other Services

Cindy has received services from the MHMR Center, Texas Cerebral Palsy Center, and the City Day Programming Center.

VII. Summary and Services Requested

Cindy is a 15-year 5-month-old female who is non-ambulatory. She lives at home with her family. This family requests day programming for Cindy, possibly through the Day Center program. They would like programming to focus on physical therapy, academic training, and improvement of self-help skills. They are very interested in becoming involved in her program and would like to do training activities in their home. The parents are actively involved in the Association for Retarded Citizens and appeared quite knowledgeable about mental retardation and cerebral palsy and, in addition, are citizen advocates for two mentally retarded children. It is recommended by this case-worker that Cindy be considered for the Day Center and that the parents be informed of our social worker's parent groups.

K. C. Worker

K. C. Worker, A.S.S.W.

CURRENT PSYCHOLOGICAL REPORT

Name: Cindy
Date of Testing: 7/21/76
Sex: Female

Case Number: 000000
Date of Birth: 2/30/61
Examiner: Psyche Rorshack

REASON FOR REFERRAL: Cindy was referred to determine current level of functioning and appropriateness for the Day Center program service.

PREVIOUS TEST RESULTS: None available.

TESTS ADMINISTERED: Stanford-Binet Intelligence Scale, Form L-M; Vineland Social Maturity Scale, mother informant.

BEHAVIORAL OBSERVATIONS: Cindy remained in her wheelchair throughout the evaluation. Cindy did not easily separate from her parents and repeatedly asked, "Where going?" Inside the testing room Cindy appeared comfortable and in no distress. It is reported that Cindy is visually impaired; however, the extent of her vision is not yet determined. Cindy appeared to enjoy most of the tasks presented and interacting socially with the examiner. She was observed to laugh and smile appropriately to the situation. Cindy was observed to localize sounds readily and when unable to localize the examiner by auditory cues she often called out to inquire as to her whereabouts. Cindy responded appropriately to simple questions

and requests in which speech intelligibility was fair. Her responses to the same questions, however, were often inconsistent. Spasticity was present in upper and lower extremities and she held her hands predominantly in a fisted position with forearms pronated. Cindy appeared to have great difficulty in grasping and releasing objects. Cindy appeared to respond well to social praise.

TEST RESULTS: Due to visual and motor handicaps only verbal items on the Stanford-Binet were administered and thus no mental age or IQ score was derived. Cindy was able to correctly respond to verbal items inconsistently through the year VI level. She inconsistently identified body parts and could explain "Why do we have houses" and "stoves" and could explain "What do we do with our eyes" and "ears." She appeared particularly limited in the extent of her vocabulary, which reflected an almost complete lack of understanding concerning visual items.

On the Vineland Social Maturity Scale, Cindy's mother informant, a social age equivalency of 1.53 years and a social quotient of 10 was derived. Areas of particular weakness include gross and fine motor skills and self-help skills with her greatest strengths in the areas of communication. Cindy's mother reported Cindy is on a soft diet and finger feeds with difficulty. Cindy indicates when she needs to use the bathroom and passively assists in dressing and undressing.

It is felt that Cindy is currently functioning in the severe to moderate range of mental retardation.

ADAPTIVE BEHAVIOR LEVEL:

Current: III-II Potential: I

SUMMARY: Cindy, a 15-year 5-month-old female, is currently functioning in the severe to moderate range of mental retardation. Her visual handicap in conjunction with a cerebral palsy motor dysfunction severely limited her ability to participate in most standardized intelligence tests. Cindy's strengths are in her communication skills and her social skills, particularly her interest in other people. Cindy appears limited in gross and fine motor skills, self-help skills, and ability to attend to tasks appropriately.

RECOMMENDATIONS:

1. Individualized programming services from the Day Center.
2. Programming should include:
   a. Self-help skills program, emphasizing initially eating with a spoon independently (adaptive feeding equipment may be necessary).
   b. Daily recreation therapy to encourage active movement in normal patterns.
   c. Speech and language program to include increasing her vocabulary and increasing consistent appropriate responses to simple questions.
   d. Tactile cues emphasized in teaching the identification and discrimination of common objects.
   e. Program to teach uses and definitions of common environmental objects.
   f. Behavioral training to increase ability to attend to tasks appropriately.
3. Occupational therapy assessment.
4. An opthalmological evaluation to determine Cindy's visual abilities.

Psyche Rorshack

Psyche Rorshack, M.S.
Psychological Associate

SPEECH AND LANGUAGE EVALUATION

NAME: Cindy
DOB: 2/30/61
SEX: Female

DATE: 7/21/76
CA: 15 years, 5 mos.
EXAMINER: Lang Gwidge

Cindy, 15 years, 5 months, was accompanied to the evaluation by her parents. She sat upright in a wheelchair with her legs extended. Very little speech and language testing could be accomplished, due to Cindy's impaired vision. She demonstrated some inappropriate behavior mannerisms during the testing session, although she smiled appropriately. Cindy could answer familiar questions appropriately, and when she did not know the answer, she was silent. Her responses to questions were somewhat delayed. Some drooling was noted when she engaged in an activity.

Cindy's expressive language consisted of four- to five-word spontaneous phrases and sentences; Cindy also asked questions spontaneously, such as "What is it?" and "What are you going to do?" When Cindy was asked to imitate sentences that the examiner said, she often omitted words in the sentence and interchanged pronouns ("me" for "I"). Some dysarthria was noted in her speech, with nasality, slightly monotonous inflections, and lower pitch. Breath support also appeared to be erratic. The Goldman-Fristoe Test of Articulation was administered by imitation, and Cindy's errors were characterized by substitutions and omissions of consonant phonemes. Speech intelligibility in spontaneous phrases and sentences was only fair.

Hearing sensitivity was not formally assessed on this date, but Cindy responded quickly to environmental sounds, and localized without hesitation. She apparently used her hearing to compensate for her lack of visual localization.

An oral peripheral examination could not be completed due to Cindy's unwillingness to cooperate. Cindy appeared to have a mild open bite, and moderate distoclusion of the teeth. Her tongue often stays anterior in her mouth; there was some facial grimacing as a result of the cerebral palsy.

SUMMARY AND RECOMMENDATIONS:

Cindy, 15 years, 5 mos., appeared to be functioning at a severely delayed level in most speech and language abilities. Her receptive language appeared to be functional for familiar questions and directions, and her expressive language consisted of four- to five-word phrases and sentences, characterized by grammatical and syntactical errors. Dysarthria, nasality, slightly monotonous inflections, and lower pitch were also noted. Speech intelligibility in spontaneous phrases and sentences was only fair. Hearing sensitivity was not formally assessed on this date. Cindy demonstrated several inappropriate behavior mannerisms during the testing session.

It was recommended that Cindy be enrolled in the Day Center, with emphasis in her speech and language program on responding appropriately to questions, controlling drooling during activity, increasing receptive language, improving sentences and phrase structures, learning vital information such as name, address, city, state, birthdate, and telephone number.

Lang Gwidge

Lang Gwidge, M.A.
Communication Specialist

APPENDIX D

EXAMPLES OF IPP FORMS

IPP FORMS

The written IPP need not duplicate information already contained in the case folder. However, it should reflect a synthesis of the data in the strengths/needs section. The remainder of the IPP needs to describe specifically that individual's future in connection with your agency.

The form for recording the IPP used in Session 6 is not intended to represent the ultimate example. The format you develop and use should reflect the needs of your clients and your agency. This may have already been determined by your agency and may or may not be subject to revision. If changes in forms are needed, now would be an appropriate time to consider them.

The following are examples of how different agencies have adapted a form to meet their needs. They may provide you with ideas on how to revise your current format or develop a new one if needed.

Rehabilitation Plan

Work Sample Evaluation:

Strengths	Deficits
_____	_____
_____	_____
_____	_____

LEVEL II: Work Activity _____

Client Objectives (Based on above information):

Long-term Goals: _____

_____

_____ Review Date: _____

Short-term Goals: _____

_____

_____ Review Date: _____

Training Procedures: _____

_____

_____

_____	_____
Service Coordinator	Trainer
_____	_____
Program Supervisor	Trainer
_____	_____
Evaluation Aide	Trainer
_____	_____
Shop Foreman	Trainer
_____	_____
V.R. Counselor	Program Consultant
_____	_____
Parent or Client	Other

INDIVIDUAL PROGRAM PLAN

NAME _____ COORDINATOR _____

DATE _____ _____ CASE# _____

DEVELOPMENT

GOALS	OBJECTIVES	MODES OF INTERVENTION	EVALUATION PROCEDURE

CURRENT PROGRAMMING:

RECOMMENDATIONS:

SIGNATURE OF CLIENT COORDINATOR SIGNATURE OF PARENT SIGNATURE OF CLIENT

INDIVIDUAL PROGRAM PLAN

TIME PERIOD _____ TO _____

CLIENT: _____ CASE NUMBER: _____

CASE COORDINATOR: _____ D.O.B.: _____

GOAL	OBJECTIVE	STRATEGY	PROGRAM(S)	EVALUATION PROCEDURE	BARRIERS	OBJECTIVE ACCOMPLISHED (DATE)

INDIVIDUAL PROGRAM PLAN

2-9-76
STAGE: _____

NAME: _____
CASE#: _____
DATE: _____

SHORT RANGE GOALS	TECHNIQUES	EVALUATION PROCEDURES	PERSON RESPONSIBLE

IPP

Name _____ Date _____ Client # _____

STRENGTHS	*NEEDS*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I. Goal: _____

A. Objective: _____

_____

1. Strategy: Who: _____ When: _____

What: _____

_____

a. Process Evaluation: _____

_____

b. Outcome Evaluation: _____

2. Strategy: Who: _____ When: _____

What: _____

_____

a. Process Evaluation: _____

_____

b. Outcome Evaluation: _____

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3. Strategy: Who: _____ When: _____

What: _____

_____

a. Process Evaluation: _____

_____

b. Outcome Evaluation: _____

II. Goal: _____

A. Objective: _____

_____

1. Strategy: Who: _____ When: _____

What: _____

_____

a. Process Evaluation: _____

_____

b. Outcome Evaluation: _____

2. Strategy: Who: _____ When: _____

What: _____

_____

a. Process Evaluation: _____

_____

b. Outcome Evaluation: _____

3. Strategy: Who: _____ When: _____

What: _____

_____

a. Process Evaluation: _____

_____

b. Outcome Evaluation: _____

RESOURCES

The resources are listed according to the following categories.

I. References

- A. Developmental Disabilities Texts
  1. General
  2. Mental Retardation
  3. Epilepsy
  4. Cerebral Palsy
  5. Autism
- B. Legal Rights
- C. The Interdisciplinary Team
- D. Goals and Objectives
- E. Strategies
- F. Evaluation

II. Developmental Disabilities Organizations and Resource Centers

- A. General
- B. Mental Retardation
- C. Epilepsy
- D. Cerebral Palsy
- E. Autism
- F. Clearinghouses, Research and Training Centers, University Affilitated Programs

I. References

A. Developmental Disabilities Texts

1. General

Cobb, B. *Medical and psychological aspects of disability.* Springfield, IL: Charles C. Thomas, 1973.

Stephenson, D., McWilliams, S., & Fisher, I. *Handicapping conditions: A resource book.* Washington, DC: DHEW, Office of Handicapped Individuals, 1975.

Telford, C. W., & Sawrey, J. M. *The exceptional individual.* Englewood Cliffs, NJ: Prentice-Hall, 1972.

2. Mental Retardation

Baroff, G. S. *Mental retardation: Nature, cause and management.* Washington, DC: Hemisphere Publishing Corporation, 1974.

Conley, R. *The economics of mental retardation.* Baltimore: Johns Hopkins Press, 1973.

Ellis, N. (Ed.). *International review of research in mental retardation* (7 vols.). New York: Academic Press, 1973.

Farber, B. *Mental retardation: Its social context and social consequences.* Boston: Houghton-Mifflin, 1968.

Parham, J. D. *An orientation to mental retardation for the vocational rehabilitation counselor.* Lubbock, TX: Texas Tech University, Research and Training Center in Mental Retardation, 1976. (slide/tape and supplement)

Robertson, H., & Robertson, N. *The mentally retarded child: A psychological approach.* New York: McGraw-Hill, 1965.

3. Epilepsy

Basic statistics on the epilepsies. Washington, DC: Epilepsy Foundation of America.

Lennox, W. G. *Epilepsy and related disorders.* Boston: Littlefield-Brown, 1960.

Sheldon, M. E., Parham, J. D., Brown, B. F., & Carter, W. W. *Epilepsy: Need assessment for the panhandle of Texas.* Amarillo, TX: High Plains Epilepsy Association, 1976.

Wright, G. N. (Ed.). *Epilepsy rehabilitation.* Boston: Little, Brown & Company, 1975.

4. Cerebral Palsy

Bobath, K., & Bobath, B. Cerebral palsy. In P. H. Pearson & C. E. Williams (Eds.), *Physical therapy services in the developmental disabilities.* Springfield, IL: Charles C. Thomas, 1972.

Cruickshank, W. M. (Ed.). *Cerebral Palsy: Its individual and community problems.* New York: Syracuse University Press, 1966.

Denhoff, E., & Robinault, I. *Cerebral Palsy and related disorders: A developmental approach to dysfunction.* New York: McGraw-Hill, 1960.

Finnie, N. R. *Handling the young cerebral palsy child at home.* New York: E. P. Dutton & Company, Inc., 1970.

5. Autism

Deslauriers, A., & Carlson, C. *Your child is asleep: Early infantile autism: Etiology, treatment, parental influences.* Homewood, IL: Dorsey Press, 1969.

Facts about autism. Rockville, MD: National Institute of Mental Health.

Ferster, L. B., & DeMyer, M. K. A method for the experimental analysis of the behavior of autistic children. *American Journal of Orthopsychiatry,* 1968, *32,* 89-98.

Gallagher, J. J., & Wiegerink, R. *Educational strategies for the autistic child.* Unpublished manuscript, 1973. (Available from Frank Porter Graham Child Development Center, Chapel Hill, NC.)

Ornetz, E. M., & Ritvo, E. R. The syndrome of autism: A critical review. *American Journal of Psychiatry,* 1976, *133,* 609-621.

Rimland, B. *Infantile autism: The syndrome and its implications for a neural theory of behavior.* New York: Appleton-Century-Crofts, 1964.

Ritvo, E. R. (Ed.). *Autism: Diagnosis, current research and management.* New York: Spectrum Publications, 1976.

Rutter, M. The development of infantile autism. In S. Chess & A. Tomas (Eds.), *Annual progress in child psychiatry and child development.* New York: Brunner/Mazel, 1975.

Wing, L. *Children apart.* Albany, NY: National Society for Autistic Children, 1975.

Wing, L. (Ed.). *Early childhood autism: Clinical, educational and social aspects.* Elmsford, NY: Pergamon Press, 1976.

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B. Legal Rights

Aquilina, R. I. Revolutionary legislation for a bicentennial year. *Education and Training of the Mentally Retarded,* 1976, *7,* 189-196.

Baucom, L. D., & Bensberg, G. J. (Eds.). *Advocacy systems for persons with developmental disabilities: Contexts, components, and resources.* Lubbock, TX: Texas Tech University, Research and Training Center in Mental Retardation, 1977.

Bensberg, G., & Rude, C. (Eds.). *Advocacy systems for the developmentally disabled.* Lubbock, TX: Texas Tech University, Research and Training Center in Mental Retardation, 1976.

Biklen, D. *Let our children go.* Syracuse, NY: Human Policy Press, 1974.

Sigelman, C. K. (Ed.). *Protective services and citizen advocacy.* Lubbock, TX: Texas Tech University, Research and Training Center in Mental Retardation, 1974. (Monograph no. 3)

Wolfensberger, W. *The principle of normalization and human services.* Toronto, Canada: National Institute on Mental Retardation, 1972.

C. The Interdisciplinary Team

Crosby, K. G. *Essentials of active programming.* Chicago: Joint Commission on Accreditation of Hospitals, 1975.

Hensley, G., & Patterson, V. (Eds.). *Interdisciplinary programming for infants with known or suspected cerebral dysfunctions.* Boulder, CO: Western Interstate Commission for Higher Education, 1970.

Hills, W. G., Scurlock, V. C., Viaille, H. E., & West, J. A. (Eds.). *Conducting the people's business.* Norman, OK: University of Oklahoma Press, 1973.

Scott, W. G. Organizational theory: An overview and an appraisal. *Journal of the Academy of Management,* 1961, *4,* 7-27.

D. Goals and Objectives

Bensberg, G. J., & Sigelman, C. K. Definitions and prevalence. In L. L. Loyd (Ed.), *Communication assessment and intervention strategies.* Baltimore: University Park Press, 1976.

Gallagher, J. J., Surles, R. C., & Hayes, A. E. Program planning and evaluation. In *First chance for children* (Vol. 2). Chapel Hill, NC: Frank Porter Graham Child Development Center, 1973.

Houts, P. S., & Scott, R. A. *Goal planning with developmentally disabled persons.* Hershey, PA: The Commonwealth of Pennsylvania, 1975.

Lindsley, O. R. Direct measurement and prosthesis of retarded behavior. *Journal of Education,* 1964, *147,* 62-81.

Mager, R. F. *Preparing instructional objectives.* Belmont, CA: Fearon Publishers, 1961.

Mager, R. F. *Developing attitude toward learning.* Belmont, CA: Lear Siegler, Inc./ Fearon Publishers, 1968.

E. Strategies

Bensberg, G. J. (Ed.). *Teaching the mentally retarded: A handbook for ward personnel.* Atlanta, GA: Southern Regional Education Board, 1965.

Flexer, R. W., & Boyd, K. L. *Teaching money skills to the mentally retarded person: A manual of procedures.* Lubbock, TX: Texas Tech University, Research and Training Center in Mental Retardation, 1976.

Flexer, R. W., Martin, A. S., & Friedenberg, W. P. *Increasing the productivity of the severely retarded with monetary reinforcement: Developing a work ethic.* Lubbock, TX: Texas Tech University, Research and Training Center in Mental Retardation, 1977.

Foxx, R. M., & Azrin, N. H. *Toilet training the retarded: A rapid program for daytime and nighttime independent toileting.* Champaign, IL: Research Press, 1973.

Franks, C. M. (Ed.). *Behavioral therapy: Appraisal and status.* New York: McGraw-Hill, 1969.

Gardner, W. I. *Behavior modification in mental retardation: The education and rehabilitation of the mentally retarded adolescent adult.* New York: Aldine•Atherton, Inc., 1971.

Gold, M. W. *Try another way.* Indianapolis: Film Productions of Indianapolis, 1975. (film)

Gold, M. W. *Vocational skill functioning of the severely retarded.* Champaign, IL: University of Illinois, Institute for Child Behavior and Development, 1976.

Gold, M. W. *Task Analysis: A statement and an example using acquisition and production of a complex assembly task by the retarded blind.* Champaign, IL: University of Illinois, Institute for Child Behavior and Development, 1976.

Hall, V. R. *Behavior management series* (3rd ed.). Lawrence, KS: H & H Enterprises, Inc., 1974.

Lent, J. R., & Keilitz, I. *How to do MORE: A manual of basic teaching strategies.* Belview, WA: Edmark Associates, 1974.

Martin, A. S., & Flexer, R. W. *Three studies on training work skills and work adjustment with the severely retarded.* Lubbock, TX: Texas Tech University, Research and Training Center in Mental Retardation, 1975. (Monograph no. 5)

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Martin, A. S., Friedenberg, W. P., & Flexer, R. W. Applied learning technology in vocational training of the severely retarded. In *Symposium on applied learning technology for minorities and the handicapped* (Vol. 5). Buffalo, NY: Calspan-graphics, 1976.

Myers, D. G., Sinco, M. E., & Stalma, E. S. *The right to education child.* Springfield, IL: Charles C. Thomas, 1973.

F. Evaluation

Mager, R. F., & Pipe, P. *Analyzing performance problems or "You really oughta wanna."* Belmont, CA: Lear Siegler, Inc./Fearon Publishers, 1970.

Rossi, P., & Walter, W. (Eds.). *Evaluating social problems: Theory, practice and politics.* New York: Seminar Press, 1972.

Schulberg, H. C., Alan, S., & Frank, B. (Eds.). *Program evaluation in the health field.* New York: Behavioral Publishers, 1969.

Sze, W. C., & Hopps, J. G. (Eds.). *Evaluation and accountability in human service programs.* Cambridge, MA: Schenkman Publishing Co., 1974.

II. Developmental Disabilities Organizations and Resource Centers

A. General

Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons (875 N. Michigan Avenue, Suite 2201, Chicago, IL 60611)

American Association for Health, Physical Education and Recreation (1201 16th Street, NW, Washington, DC 20036)

American Coalition of Citizens with Disabilities (1346 Connecticut Avenue, Washington, DC 20036)

American Occupational Therapy Association, Inc. (251 Park Avenue South, New York, NY 10010)

American Rehabilitation Counseling Association, American Personnel and Guidance Association (1607 New Hampshire Avenue, NW, Washington, DC 20009)

Association of Rehabilitation Facilities (5530 Wisconsin Avenue, Suite 955, Washington, DC 20015)

Bureau of Education for the Handicapped, U.S. Office of Education (Washington, DC 20202)

Center for Human Policy (216 Ostrom Avenue, Syracuse, NY 13201)

The Council for Exceptional Children (1920 Association Drive, Reston, VA 22091)

Developmental Disabilities Office, Office of Human Development (330 C Street, SW, Room 3330, Washington, DC 20201)

Developmental Disabilities/Technical Assistance System (Suite 300, NCNB Plaza, 136 E. Rosemary Street, Chapel Hill, NC 27514)

Frank Porter Graham Child Development Center (University of North Carolina, Chapel Hill, NC 27514)

Goodwill Industries of America, Inc. (9200 Wisconsin Avenue, Washington, DC 20014)

International Association for Music Therapy, Inc. (Box 610, Lawrence, KS 66055)

National Center for Law and the Handicapped (Logan Center, 1235 North Eddy Street, South Bend, IN 46617)

National Institute of Mental Health (5600 Fishers Lane, Rockville, MD 20852)

National Rehabilitation Association (1522 K Street, NW, Washington, DC 20005)

National Easter Seal Society for Crippled Children and Adults (2023 West Ogden Avenue, Chicago, IL 60612)

President's Committee on Employment of the Handicapped (1111 20th Street, NW, Washington, DC 20210)

White House Conference on Handicapped Individuals (1832 M Street, NW, Suite 801, Washington, DC 20036)

B. Mental Retaradation

American Association on Mental Deficiency (5201 Connecticut Avenue, NW, Washington, DC 20015)

Joseph P. Kennedy, Jr. Foundation (719 13th Street, NW, Washington, DC 20015)

National Association for Retarded Citizens (2709 Avenue E East, Arlington, TX 76011)

President's Committee on Mental Retardation (Seventh and D Streets, SW, Washington, DC 20024)

C. Epilepsy

Epilepsy Foundation of America (1828 L Street, NW, Washington, DC 20036)

National Epilepsy League, Inc. (203 N. Wabash Avenue, Room 2200, Chicago, IL 60601)

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D. Cerebral Palsy

American Academy for Cerebral Palsy (University Hospital School, Iowa City, IA 52240)

United Cerebral Palsy Association, Inc. (66 E. 34th Street, New York, NY 10016)

E. Autism

National Clearinghouse for Mental Health Information (11400 Rockville Pike, Rockville, MD 25702)

National Institute of Neurological and Communicative Disorders and Stroke (Rockville Pike, Bethesda, MD 20014)

National Society for Autistic Children (169 Tampa Avenue, Albany, NY 12208)

National Society for Autistic Children, Information and Referral Service (306 31st Street, Huntington, WV 25702)

F. Clearinghouses, Research and Training Centers, University Affiliated Programs

Association of University Affiliated Programs (2611 P Street, NW, Washington, DC 20007)

Materials Development Center (Department of Rehabilitation and Manpower Services, School of Education, University of Wisconsin-Stout, Menomonie, WI 54751)

Mental Retardation Rehabilitation Research and Training Center (351 Clinical Services Building, College of Education, University of Oregon, Eugene, OR 97403)

National Clearinghouse of Rehabilitation Materials (Oklahoma State University, Stillwater, OK 74074)

Rehabilitation Training Materials Study, Medical Rehabilitation Research and Training Center, George Washington University (2300 Eye Street, NW, Washington, DC 21137)

Waisman Center on Mental Retardation and Human Development, University of Wisconsin (2605 Marsh Lane, Madison, WI 53706)